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**COLLABORATIVE CARE PLANNING:
MENTAL HEALTH SERVICE
USERS PERSPECTIVES**

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A submission presented in partial fulfilment of the requirement of the University of Glamorgan/Prifysgol Morgannwg for the degree of Master of Philosophy, April 2000.

Declaration

I declare that this work is the result of my own effort, and that all quotations from books have been acknowledged.

Signed: 

Date *April, 2000.*

ACKNOWLEDGEMENTS

I am sincerely indebted to the following people for their assistance in the completion of this work. First most importantly I wish to acknowledge the service-users and the health professionals who kindly helped in the study.

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ABSTRACT

Collaborative care planning (CCP) was defined as MHS users and health professionals working together to decide care plans in a relationship that recognises equality, and encourages the shared power to decide, in an atmosphere of mutual understanding and respect for each others' contribution.

This descriptive study used both quantitative and qualitative approaches to address the following objectives.

Objectives:

- To find out the conceptual understanding of the meaning of the term CCP.
- To determine the role of MHS users in the decision-making process.
- To determine whether the social environment is conducive to CCP.

Methods and data collection: A quantitative approach was used in which a convenience population of 72 respondents (55 mental health service users and 17 health professionals) in day care units, completed questionnaires. Approval was obtained from the local District Ethics Committee. The questionnaire had three areas: meaning of the term CCP, decision-making and social environment. A simple descriptive statistical analysis showed that 6% of the MHS users were aware of the term CCP. Eighty per cent of the respondents indicated a desire to be involved in decision making about their care whilst 15% did not. Forty-two per cent of MHS users thought seeing their records the most important aspect of care.

The qualitative approach used a 30-60 minute semi-structured interview format utilising a critical incident technique. Data were collected from a purposive sample of 10 MHS users discharged from hospital for between 6 months and 3 years. Five health professionals were interviewed without the use of the critical incident technique. Five themes emerged following critical analysis of 'critical happenings'. These were: 'classification of incidents', 'involvement and non-involvement', 'imbalance of power', 'contextual factors' and the 'tone of the incidents'.

Conclusions:

There is no universal understanding of the term collaborative care planning between users and health professionals. In reality, within the clinical context, users were not actively involved in deciding care plans with health professionals.

Implication for practice: Mental health professionals may involve users as equal partners in the planning and delivery of care.

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Chapter One

- Introduction
- Background
- The Research Question

CHAPTER 1

INTRODUCTION

1. Introduction.

Currently a greater importance is attached to the mental health service users (MHS users) views on the quality of services provided (DoH, 1995). More importantly health professionals are being urged to take in to account MHS users' views when planning and delivering care. Such views are encouraged and considered desirable (FitzPatrick, 1997). The current impetus has stemmed from successive Government initiatives, which emphasise patient choice and voice in the management of health needs (DoH 1989; DoH 1994; DoH 1995; and notably (Welsh Office, 1998). Of these government initiatives, Working in Partnership report, (DoH, 1994a) in its review of mental health nursing, has stated explicitly the need for a collaborative approach to care between the users and multi-professionals. The call is being made in the absence of valid research to indicate that users wish to participate in the planning and delivery of services (Biley 1992).

There appears to be an exiguous amount of literature pertinent to MHS user involvement in planning of their care. Political philosophy militates against the traditional thinking of perceiving patients as passive recipients of care. In the area of mental health services, research has tended to eschew including MHS users' views in research studies. Perhaps this is due to the stereotypical notion that, because of the nature of their mental illness, whatever they say is considered unreliable. Investigating some of the reasons for the dearth of research in mental health service Roger et al. (1993) conceded that a possible explanation has been the widely held assumption that users' views have no rational basis. Raphael et al. (1972) dispelled this stereotypical notion when they found that only 2% of respondents gave irrational responses to the 2,148 questionnaires exploring users' views of psychiatric hospitals. Methodological reasons could have influenced the results and not necessarily the nature of users' mental health status.

There has been a proliferation of literature seeking users' views concerning some aspects of the mental health service (McIntyre et al. 1989; McIver, 1990; Ballard and McDowell, 1990; Roger et al. 1993; Lovell, 1995). Recently McDermont (1998) has provided a MHS user perspective of the care programme approach. While there appears to be a general agreement in the need to seek MHS users' views and actively involve them in care, there is no formal framework of integrating them into the care system (Jones 1998). Despite a recent increase in the literature on users' views regarding mental health service, very little has so far related to their role in CCP. What is widely reported in the literature is simply patient participation (Ashworth, 1992; Jewell, 1994; 1996).

Operational definition

For the purpose of this study the term CCP describes a process whereby MHS users and health professionals work together to decide the plan of care in a collaborative relationship (social environment). The emphasis is on collaboration where there is mutual understanding, and MHS users' contributions are valued, respected and, are treated as of equal worth with those of the health care professionals. To this end it is essential to know whether both parties involved in care delivery perceive collaboration in care planning in the same light. It is important to seek MHS users' views on items that have a particular relevance to them and have been translated into language that is familiar to them.

1.1 Background to the Study

Collaborative care planning as an issue

In order to place this study among other studies dealing with user's perceptions, it is helpful to look at what has instigated this demand for user involvement in service provision. Traditionally, multi-disciplinary teams have worked within defined boundaries to meet the social and health needs of the user in total or partial isolation. Until recently the MHS users and informal carers had very little involvement in the planning of care delivery. This arrangement of delivery of service, in which the health care professionals have been active and guiding, whilst the MHS users have adopted a passive and co-operative position, is gradually being challenged, however there is evidence to suggest that this

arrangement still exists in the health care system (Morral, 1996).

Essentially a collaborative approach is thought to give MHS users opportunities to be involved at the service level of decision-making. While it may always have been assumed that when planning care, professionals would take some account of the views of the MHS users and their carers, there appears to date to be no clear evidence of what the MHS users think of the CCP and what they see as their role in decision making concerning their care. Primary nursing, and the use of nursing process were thought to facilitate user collaboration in planning care (Manthey 1980, Jewell 1994) yet decisions about planning care appear to be made without always involving the active contribution of users (Cahill, 1996).

A commonly accepted criticism of decision-making is that nursing actions mostly meet the needs of the institution rather than the needs of the individual (Sullivan 1998). In spite of 20 years of the nursing process, primary nursing and individualised patient care, ward routines still impinge on patient care (Robinson 1997). There appears to be no clear mechanism of involving MHS users in planning care. A framework for consultation and involvement in planning their care is needed. Asking MHS users for their views about the concept of working together would ensure that the framework is grounded in their values.

This move towards patient collaboration is happening both at policy level (DoH, 1990) and professional nursing level (DoH, 1993). Collaborative care planning is a key feature of National Health Service (NHS) (Ross, 1993). It is the process whereby the MHS users and health professionals decide collaboratively on the plan of care in order to produce what Bamsford (1993) has called seamless care, in which professional boundaries are reduced and become invisible to the users.

The nursing profession in Wales started a consultation process, to determine how best to apply CCP in practice (Welsh National Board (WNB) 1993). Subsequently a number of authors have presented different perspectives of what constituted CCP, its principles and outcomes (Rigby, 1994; Williams, 1994 and Small, 1994). The Audit Commission, (1992) believed CCP would achieve value for money.

Some studies have reported the use of CCP in different care settings, for example in orthopaedic surgery (Lancaster, 1993), and in neuroscience (Ingram, 1995; Luther and Crofts, 1997). In such instances positive outcomes of CCP are highlighted. However absence of detailed information makes it difficult to draw firm conclusions about the role of users in CCP. The literature search has revealed an absence of empirical work concerning MHS users' views about CCP.

The need to research CCP.

Involving MHS users in care planning is an accepted requirement of good practice (DoH 1995). Yet in practice, although the nurses have embraced the concept of patient centred care, there is evidence to suggest that MHS user involvement in decision-making is nothing but tokenism (Beresford and Croft 1995). The service providers are viewed as paying lip service to the idea of MHS users collaborating with care planning (Lindow 1992).

A number of authors believe that CCP is a response to solving problems created by the desire to curtail public expenditure whilst ensuring an effective health care system (Audit Commissioner 1994; Allsop 1995; Hale 1995; Benton 1995). This could be achieved through efficient use of resources available, at the same time rendering a highest possible quality of care for all patients (Audit Commission, 1992). The mechanism to accomplish this was thought to be the collaborative care model of delivering service, thus facilitating the pooling of resources. The debate regarding CCP is underway, it is important to have a conceptual understanding of collaboration.

Conceptual definition of Collaboration

The concept of collaboration is not clearly defined. There appear to be various definitions of the term "collaboration." (Miccolo and Spanner 1993; King, 1993 Henneman et al, 1995). There is a lack of consensus regarding the essential criteria of collaboration (Weis and Davis, 1985; Miccolo and Spanner 1993).

Patient participation, patient involvement, patient partnership and negotiation are often used interchangeably with patient collaboration (Brearley, 1990; Jewell,

1994). The concept of patient participation has been widely examined (Brearley, 1990; Biley, 1992; Ashworth et al, 1992; Jewell, 1994 and; Cahill 1996) all of them taking place in either within a surgical or medical context. The literature reveals that, even then, there is lack of clear consensus and clarity. Different orientations towards patient participation have resulted in misunderstanding of the role of either the nurse or user (Clayton, 1988).

There is a scarcity of information on the MHS user involvement in CCP and asking their views would clarify their role. There is no clear agreement on what patient collaboration entails, nor is the role of MHS user in decision making clearly stated.

1.2 Rationale of the Research

The researcher was interested to carry out the study for two reasons: First, health professionals are being encouraged to involve users in CCP, but they may not know what it is. Debate surrounding CCP tends to encompass other inter-related concepts (participation, involvement and negotiation) so it is not clear whether collaboration is synonymous with them. MHS users are more aware of consumer rights and increased knowledge through government documents (Patients charter, 1992; Involving the public, 1998) and it is increasingly becoming an expectation for patients to take part in many aspects of care (DoH 1995; Iskander 1999).

Second, asking MHS users and health professionals for their views about CCP would promote an understanding of what strategies to adopt and what skills or knowledge are needed to enable an effective working relationship between health professionals and MHS users.

Following informal inquiries with some of mental health care professionals, the researcher determined the extent to which CCP was currently applied in practice. On that premise the study was justifiable to elicit the views of the MHS users from the corresponding care settings. This study aims also to provide some insight into other related concepts that tend to be used interchangeably with patient collaboration.

1.3 The Research Questions

There is an emphasis on involvement of MHS users at all levels as an integral part of the care delivery (Glenister et al, 1994), this stance would appear to be adopted in the absence of conclusive firm evidence to show whether all MHS users and health care professionals involved in working together have a common understanding of the concept.

The research questions:

- What are the views of MHS users and health professionals regarding the concept of CCP in the context of the mental health service?
- What does the literature say about user collaboration in the mental health context?

The answer to these two questions will illuminate the MHS users' role in decision-making and also provide a comprehensive picture of the state of knowledge on patient collaboration in order to inform practice.

1.4 Objectives of the study

To guide the study the objectives are to:

- Find out the conceptual understanding of the meaning of the term CCP
- Determine the role of MHS users in the decision making process
- Ascertain whether health professionals think the MHS users are aware of the term CCP
- Elicit whether personal characteristics influence MHS users' views about their involvement in decision-making?
- Ascertain to what extent MHS users would wish to be involved in decision-making.

- To find out how MHS users would wish to see the decision making process take place
- Determine what role the social environment has on the ‘working together’ approach to care between MHS users and health professionals?

1.5 Definitions of Terms

- **Social environment** is the relationship between the health care professionals and MHS users that recognises equality and promotes shared power of deciding, where users feel in control of their care. There must be mutual understanding and respect for each other’s contribution to planning care.
- **Service-user** is the term consistent with the present political thinking. A user is an individual who is currently using or has used health and social services (National Schizophrenia Fellowship, 1992). It has been used in a number of documents, for example, working in partnership (DoH, 1994; NHS and Community Care Act, DoH, 1990; Involving the Public, DoH, 1998). MHS user relates to an individual who is using any facility related to the mental health service.

1.6 Delimitation

According to Creswell (1994) some indication has to be made to show the limit of the study. This current study is confined within parameters of investigating MHS users views about CCP 1989-1998 when CCP was of great prominence (Lewis, 1993; WNB, 1994 and DoH, 1995). The study recognises that other concepts related to CCP have become widely known in the meantime.

Chapter Two

- Introduction
- Collaborative Care Planning
- Decision-making
- Social Environment

CHAPTER 2

REVIEW OF LITERATURE

2. Introduction:

The current study aims to describe the views of the MHS users in relation to CCP. There are few studies pertaining to CCP in the mental health service; Creswell (1994) suggests a use of studies as close as possible to the topic, to “review studies that address the topic at a general level” (p 29).

The search method used in this study started by searching MEDLINE electronic database, between 1986-1996 using the key words “collaboration”, “care” and “planning”, “social environment”. Then changed to other the databases such as CINAHL, NURSING COLLECTION but retained the same key words. Searches were employed using the key words either separately or in combination. The studies identified were read to determine their relevance to the current study. In addition literature was obtained from the list of references cited in some articles, UK conference reports, and government reports were selected to give a clear picture of the state of knowledge. And a manual search of Psychiatric, Health and Social Care journals were carried out in an effort to define the concept of CCP. The literature search focused around and from 1989 as that was the time when the concept of CCP gained prominence in the nursing literature. At the time, there appeared to be a scarcity of empirical work in which the concept was examined within the mental health care system. However, there were numerous references in relation to the key word collaboration. In American literature the term CCP appears to be commonly employed to refer to a joint practice of planning care between physicians and nurses.

Most of the publications on CCP tend to be theoretical discussions and anecdotal accounts of the principles and outcomes. With that in mind, the review attempts to establish the importance of the current study and also provide a benchmark for comparison between the results and other findings (Creswell, 1994).

The review of literature has revealed many publications relating to collaborative practice or collaborative care. Often these are used interchangeably. Some authors have concentrated on collaborative behaviours conducive to achievement of collaboration (McLain, 1988 and Baggs, 1994); others have developed instruments to demonstrate the existence of collaborative practice (Weis and Davis, 1985; Baggs et al, 1992). What is noticeable, however, is that the studies concerning collaboration that originate in North America tend to focus on the collaboration between physicians and nurses, not between users and health professionals.

In the U.K the impetus of promoting CCP is gaining momentum. There is a shift towards individualised responsibility representing a convergence of both political initiatives and views within the nursing profession about a mode of care that is genuinely participative (May, 1995). The call is for the service-user to be actively involved in the organisation and delivery of care (NHS and Community Care, 1990; Welsh Office 1998). As a consequence, a proliferation of studies has emerged eliciting views of the users about all aspects of service delivery. Interest has grown especially in the area of patient participation in decision-making regarding their care (Jewell, 1994; 1996; Shemmings and Shemmings, 1995; FitzPatrick 1997, Cahill, 1998).

The debate on patient participation is not new, it goes as far back as 1950s (Szasz and Hollander 1956 cited in Trandel-Korechuk, 1982; Quill, 1983; Pritchard, 1986). What is new is the great importance attached to users' views about service that the health professionals provide. This is a part of the broad political philosophy that emphasises individual responsibility over health issues (Involving the Public, 1998).

The other aspect to be considered is the social environment. It has a role to play in patient collaboration yet it is not often explicit in literature. Hence the studies of patient involvement in CCP need to consider the social environment aspects of care (Glenister, 1994).

2.1 Concept of Patient Collaboration Defined

Collaboration as a concept is widely used to describe a phenomenon of multi-agencies working collaboratively (Kingdom, 1992; Ross and Campbell, 1992; King et al, 1993; Miccolo and Spanier, 1993;). Collaboration between nurses and physicians appears to be a popular focus of most studies in America (Weis and Davis, 1985; McLain, 1988; Kimball et al, 1992). Noticeable in the literature are the different definitions of collaboration. For example, King et al postulate that collaboration is a process of communication:

“...Individuals may share by providing input into a discussion, decision or action” (King et al. 1993: p 444).

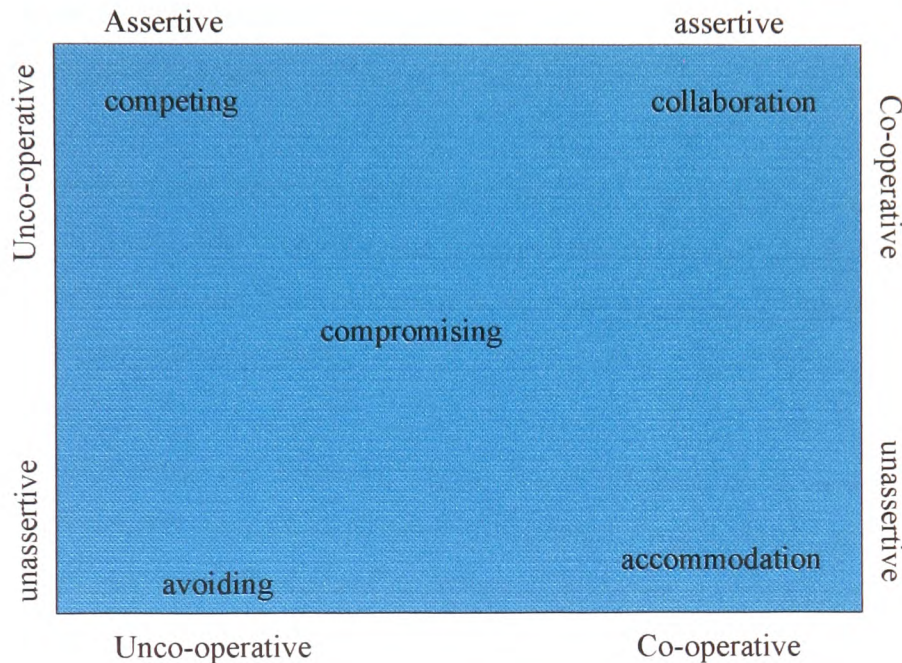
This definition includes co-ordination, co-operation and sharing of ideas. Miccolo and Spanier (1993) believe collaboration indicates a pattern of working together especially on an intellectual basis. An explanation of “ intellectual basis “ would have been helpful: otherwise the meaning is open to variable interpretation.

Baggs (1994) provides a definition that stems from the work of Thomas (1980), an interpersonal theorist in conflict resolution. This conceptual model incorporates five behaviours that can be displayed in a conflict resolution-compromise, competition, avoidance, collaboration and accommodation. In resolving a problem a combination of high level of co-operativeness (to satisfy other people’s concerns) and assertiveness (concerns to satisfy ones own interest) results in collaboration. This means that a participant in a discussion needs to co-operate with other peoples’ ideas and be assertive enough to express own ideas. In a compromise a participant largely co-operates with others’ ideas at the expense of his or her own. (See figure 1). The model suggests that in collaboration an individual asserts him/herself in expressing and satisfying his/her own concern at the same time, in order to reach an integrative solution one has to co-operate with other people’s ideas. Within this model, the concept of collaboration is perceived as an interpersonal behaviour defined in relation to other behaviours (Weis and Davis, 1985; McLain, 1988; and Baggs et al, 1992). Therefore, it could be argued that in a state of collaboration, health professionals’ and MHS users’ concerns are

recognised and important concerns are not compromised

Figure 1: Two dimensions of conflict behaviour

Co-operative ness + assertiveness= Collaboration



Source: Adopted from Thomas 1980 cited in Baggs et al, 1992.

Patient collaboration and other related concepts

Collaboration is often used interchangeably with such terms as partnership (Teasdale, 1987) participation (Brearley, 1990; Ashworth et al, 1992; Biley, 1992 Jewell, 1994;) or negotiation (Quill, 1983; Trnobranski, 1994). In participation an individual becomes actively involved or shares in the nature of something with others (Sinclair, 1993). This implies that the individual may be involved in something that could be physical or intellectual. It may entail involvement of many people in the decision making process, giving rise to feelings of being in control and responsible (Holloway, 1993).

Participation means getting involved, or being allowed to get involved in the decision making process or in delivery of care, sometimes, just through being one of a number of people consulted on an issue (Brownlea, 1987). It can be seen that participation is an active process either carried out on an individual basis or

collectively. In clinical practice it has tended to be applied to patient involvement in the delivery of nursing care or treatment (Cahill, 1996). Patient involvement appears to be used synonymously with patient participation; the latter is considered at a basic level as a one way, as opposed to a two way process (Cahill, 1998). The patient might be involved by simply being physically there, without participating in any intellectual activity.

Partnership encompasses equality that demands two people working in a joint venture (Quill, 1983). This seems to suggest that the nurse and patient enter into a contract, which ensures commitment from both parties throughout the health care processes (Teasdale, 1987).

Close scrutiny of the literature reveals that although all these concepts are used interchangeably they have distinct differences. Placing them on a pyramidal arrangement it would appear that patient involvement is at the base, followed by patient participation, then patient collaboration and lastly, at the apex, is patient partnership. These concepts are all fundamental to nursing care. However there appears not be a general consensus as to the meaning and how they should be applied in practice to prevent the care delivery being seen to be at odds with the spirit of users working together with health professionals (Smith, 1988).

In the present trend where views, beliefs and values of users are sought, the health care professionals have a duty to ensure that these terms are clearer to the users in order to deliver care that meets their needs. It is evident in the literature that there is no single universal definition of collaboration (King et al, 1993) in health care.

2.1.1 Critical Attributes of Collaboration:

Some of the attributes present in collaboration are commonly found in interpersonal relationship (Miccolo and Spanier, 1993). A large number of studies have highlighted the importance of working together, embodying respect for each other's expertise and skills (Weiss and Davis, 1985; McLain, 1985; King et al, 1993). A common goal has to be achieved through effective communication, co-

operative and assertive behaviour.

One author has considered levels of collaboration. Hornby (1993) states 3 levels:

- Primary
- Secondary
- Participatory

Primary collaboration entails health care professional's initial encounter with the service-user in which the latter maintains a passive role. Secondary collaboration relates to service-users being excluded from the decision-making process. The interaction takes place between various health care groups. In participatory collaboration the service-user is genuinely involved in all stages of the decision making process. Working with more than one health care professional or in a bipartite relationship, the user is integral to the participatory process.

Armitage (1983) provides taxonomy of collaboration remarking that the essential element most often excluded is that of joint discussion in which professionals and users are involved. Most of the literature review emphasises shared responsibility, respect and value of each person's contribution regardless of hierarchical status. There appears to be a broad agreement that a non-hierarchical pattern of relationship with a horizontal style of communication is conducive to collaboration. What is noticeable, however, is the lack of data denoting users' views about collaboration. In some studies the user's role in collaboration is not explicitly articulated despite the fact that collaboration in the context of health care is of vital concern to the user. Having defined concept of collaboration, the natural progression is to consider CCP.

2.2 Collaborative Care Planning:

CCP has been regarded as the panacea to many problems arising from the traditional hierarchical and costly health care practice. It would appear to have come about as a resource management strategy. The concept of CCP appears to have originated in North America (Hewiston, 1992; Finnegan, 1993; Lancaster,

1993; Benton, 1995; Laxade and Hale, 1995; Luther and Craft, 1997). Providing a background to CCP Hewiston (1992) explained how the West Midlands Regional Health Authority Resource Management Team, on an educational tour had observed an approach to care planning, that involved the entire multi-disciplinary team. This was a form of managed care system termed collaborative care (Carlisle, 1991). Subsequently a pilot study was initiated utilising the principles of managed care system, referred to as CCP. It is an expansion of the nursing process,

“... A patient-centred, multidisciplinary team approach to care planning which uses a predetermined joint care plan”(Hewiston, 1992: p.12).

A number of authors endorse this definition but go on to include planning, monitoring and evaluation of care over a pre-determined period (Lancaster, 1993; Finnegan; 1993; Ingram, 1995). The care activities that health professionals would normally provide converge in the care plan.

The Welsh National Board (WNB) (1993) echoes similar sentiments about CCP but do not refer to predetermined outcomes. Wishing the nursing profession to discuss the philosophy of care, WNB (1994) presented a discussion paper in which the term CCP was defined as:

“An inter-disciplinary team approach to assessing, planning, implementing, monitoring and evaluating in collaboration with clients, family and friends where possible” (WNB1994: p1).

This definition is explicit in encompassing the user; it implies that the patient is an integral part of the team. Interesting to note, is how the WNB (1994) uses the term inter-disciplinary whilst others have employed the term “multi-disciplinary approach”. Gage (1994) argues that there is a difference between the two concepts. The term multi-disciplinary involves separate consultation; professionals tend to function independently of one another although all have a common goal, i.e., to help the patient. Gilmore et al (1974 cited by Gregson et al, 1991) believe differently, suggesting that the goals are located in a multi-disciplinary team whereas the interdisciplinary model necessitates collaboration and negotiation by team members to facilitate a well co-ordinated, integrated approach to care. Rigby

(1994) wonders whether CCP is in fact three separate concepts working in harmony.

Proposing that there are three interlinked concepts, those of process, protocol and personalised care plan; he provides an explanation of each concept. Firstly, as a process CCP brings people together to plan care, somehow the idea is consistent with the definition proposed by Hennenman et al (1995). In the second concept, he views the care plan as a protocol in which all the professionals in the local care setting come together, to agree on a set of normative activities. The third concept is a personalised version of the multi-disciplinary protocol and, is congruent with views expressed by Lancaster (1993; Finnegan, 1993; Ingram, 1995 and Hale 1995).

After examining each concept and how it relates to CCP, Rigby was convinced that there were three different issues that can be used in harmony. However, he warns of some issues that may need to be resolved to ensure a successful collaboration between the parties involved. There should be a common understanding of the concepts encapsulated in CCP, including the use of a unitary record system.

The Welsh National Board (1993) also proposed the use of unitary record systems and alluded to its perceived benefits to patient care. Woodward (1994), providing a social service perspective of CCP, defined it as a partnership and consultation process between users and agencies involved in providing a service. In an effort to highlight the implementation and positive outcomes of CCP, Williams (1994) concurs with Woodward (1994) in that the conceptual framework of collaboration is founded on partnership between the groups involved in effecting care.

An exploratory survey conducted by a development/research group within a school of nursing and midwifery in Wales points out that the health professional groups have a different perception of CCP (Harris 1995). Fourteen hundred questionnaires were distributed to four professional groups comprising nurses, doctors, physiotherapists and occupational therapists. One question asked which one of a number of statements best-described CCP. Interestingly, the physiotherapists and occupational therapist groups unanimously concurred with the

statement. “All professional groups, including the patient/client/relatives working together to develop an individual patient care plan”. A variation among doctors and nurse groups was noted, but overall, there was a general consensus to the statement. The response rate was disappointingly low (383 out of 1400 questionnaires) but however sufficient to facilitate analysis. It can be argued that perhaps the doctors and nurses, although working together, still maintain ‘intellectual independence’ rather than pooling together of expert knowledge as proposed by Lancaster (1993; p. 20)

“... CCP is an interaction between nurses and other care providers that enables the knowledge of all the professions to collectively influence patient care”.

Investigating user involvement in care planning, Spences et al (1997) used a survey approach to collect data from 10 MHS users. The study used a questionnaire that consisted of two sections; staff attitude and changes in the resident’s abilities. The rationale for conducting the study was clearly articulated, to elicit residents’ views about their role in care planning. The response rate is not addressed and there is no indication that informed consent was obtained, therefore, firm conclusions cannot be drawn.

Lancaster (1993) describes an introduction of CCP using an orthopaedic ward as one of the pilot sites. Unfortunately no data were included or any detailed research process of the pilot study. It is not possible to refute the claims, as there is a lack of data from which to derive any conclusions. Despite its deficiencies the paper provided an insight into the principles embedded in CCP.

The review of literature has revealed some common principles associated with CCP (Hewiston, 1992; Lancaster, 1993; Finnegan, 1993; Hale, 1995; Laxade and Hale, 1995 and Luther and Croft, 1997). A summary of these principles include:

- The multi-disciplinary approach to managing care
- The care maps that contain a list of problems, integrative interventions and expected outcomes for a particular client group, usually generated by professional groups with expert knowledge allied to the diagnostic group.
- The care map has a critical pathway, which consists of sequences of care

events to ensure that the outcomes are achieved within a set time frame.

- The variance tracking that involves a recording of deviations from the pre-planned activities. As a result, areas of change are identified and subsequent interventions developed accordingly.
- Patient-centred care plan that is based on the multi-disciplinary team care map.

The literature often alluded to a patient centred approach in CCP but rarely is the role of user made explicit. For example, Ingram (1995) describes a CCP project in a neuro-science unit that centres on patients who have had subarachnoid haemorrhage. Collaborative documentation was later piloted and implemented. A retrospective postal questionnaire was administered to determine the patient satisfaction levels. Ingram (1995) reports that the results showed greater levels of communication, but there are no detailed data to show the process.

As a result of the project a consultant modified his protocol for the patient group and Ingram remarks that

“CCP as a process serves as an ideal way of recognising contributions made by different professionals in caring for an identified group” (Ingram, 1995; p. 28).

Although this was an update on the knowledge surrounding CCP it leaves the reader with unanswered questions. It would appear that the postal questionnaire was a form of evaluation exercise following implementation of CCP. Furthermore Ingram (1995) seems to assess the level of satisfaction by the fact that the consultant modified his protocol. It is not clear whether the patients completed the questionnaire. The absence of results related to patient satisfaction levels precludes drawing judgement about the worthiness of the study.

2.2.1 The Perceived Positive Outcomes of CCP:

Some authors have attempted to demonstrate the positive outcomes of CCP; in particular, the gains incurred by patients, staff and organisations. These positive

outcomes appear to be anecdotal conclusions derived from local knowledge rather than an extensive review of literature or research findings.

From the review of literature a summary of these benefits is highlighted: These include:

- Increased user involvement (Hewiston, 1992; Finnegan, 1993; Ingram, 1995; Benton, 1995; and Scott and Cowen, 1997).
- Increased user access to their health record. This can be used to monitor progress (Hewiston, 1992; Laxade and Hale, 1995).
- Continuity of care that is co-ordinated (Zander, 1988 and Laxade and Hale, 1995).
- Opportunity for users to identify the care activities that various disciplines administer, who are expert in the diagnosis related group, (Hewiston, 1992 and Ingram, 1995).
- Increased high level of knowledge and education about the illness and treatment that the users receive (Finnegan, 1992; Lancaster, 1993 and Alder et al, 1995).
- Increased familiarity with the daily routine of care (Benton, 1995).

The benefits reported for the health care professionals include, enhancement of communication between the different professionals involved in the planning of care (Ingram, 1995; Scot and Cowen, 1997) and positive relationships between collaboration and patient care outcomes (Alder et al, 1995). In addition other authors see the gain as economic emphasising the need for cost-effective quality of care (Zander, 1988; Luther and Croft, 1997).

A range of positive outcomes is claimed, yet there are few data from which to draw conclusions. In respect of users, although the literature related to participation highlights the benefits, they do not explicitly articulate the role of the user in collaboration with care. There is no indication that the users' views were sought about their perspective of CCP.

Collaborative Practice/Care

The question must be posed whether collaborative practice and collaborative care are the same phenomenon and how they differ from CCP. In order to place the study of CCP in a wider context, it was essential to establish whether the two commonly used terms describe the same phenomenon. Most North American literature tends to describe the two concepts interchangeably. For example, Weiss and Davis, (1985); Kimball and Bush, (1993) and Bagg et al, (1992) use the term collaborative practice. They describe it as a clinical system that focuses on the achievement of patient outcomes within a stated time. Boutron et al, (1995) contend that collaborative practice is the working arrangement of physician and nurse that benefits the patient because the patient is aware of the path that the care will take and the expected length of stay in hospital.

Similarly Evans and Carlson (1992) report that collaborative practice is a joint effort that involves team orientated personnel who work within a flat structured relationship, which facilitates horizontal communication as opposed to hierarchical. The flat structured relationship assumes that participants communicate as equals but it does not refer to the service user.

A study by McLain (1988) uses a phenomenological approach. This research approach belongs to the interpretive paradigm (Parahoo, 1997) that emphasises on individual's experience of an event or phenomenon. In phenomenology, the researcher describes the phenomena experienced by participants and follows a set of procedures and guidelines in collating and analysing data.

The purpose of the study was to analyse critically the meaning of collaborative practice relationships in a primary care setting, between nurse practitioners and physicians. The research question posed was "How do physicians and nurse practitioners in an established collaborative practice interact with each other?" It examined interactive conditions in the practice that facilitate or hinder meaningful collaboration. A sample of 18 family nurse practitioners and physicians in collaborative practice were interviewed during 6 to 8 hours of actual practice. No details are provided as to the duration of the interview, nor is an example of interview extract included to give the reader an insight into the questions that were

asked, and the type of interview format is not specified. McLain (1988) used an interview guide, which most probably utilised a semi-structured format.

Two sets of interviews were conducted, first, individually and then jointly (physicians and nurses). The rationale for this arrangement was clearly articulated. One reason included was that of promoting self-reflection. This enabled the physicians and nurse practitioners to individually think about how they relate to each other. Transcribed data and summaries were returned to the respondents for validation. The research fails to provide details how the themes were derived from the interview data. The resultant themes were analysed using critical theory.

(Critical theory refers to a series of ideas that are grounded in the Frankfurt School of Sociology (Freire, 1972). The critical theory emancipates individuals from the constraints of unequal power relationship through free communication (Haberman, 1979). Embedded in the view of critical theory is the recognition that

“Things could or ought to be different” (McLain, 1988; p 393) in relation to the social structure). The study concludes that collaborative practice was not the normal pattern of working. The physician evidently failed to provide conditions conducive to an ideal speech that facilitates better relationship. McLain blames both physicians and nurses for failure to communicate. Nowhere does the study involve users.

Collaborative care is another concept widely referred to in the literature (Alpert et al, 1992; Miccolo and Spanier, 1993). Ambiguity in the use of terms increases when both collaborative practice and collaborative care are utilised, at times interchangeably. In some publications the term is used to describe the form of care delivery whilst in others it refers to the type of environment that maintains a collaborative care approach. For example, Alpert et al, (1992) in their paper entitled ‘Towards an understanding of collaboration,’ discuss how collaborative practice was introduced in what they referred to as a collaborative care unit. The unit describes in detail the application of the model of collaborative care. From their description of the model of collaboration, the two terms (collaborative practice and collaborative care) are employed synonymously.

Attempting to provide some clarity about collaboration Kimball and Bush (1993) point out the similarities between collaborative care and collaborative practice. Both systems determine patient care; promote appropriate utilisation of resources and high quality of care. This is true of collaborative care practice.

Collaborative practice or collaborative care is an interpersonal process, or a structure, that affords the smooth co-ordination of care between health care professionals and users. There is a tool to measure the existence of collaborative practice- 'Collaborative Practice Scales' (Weis and Davis 1985). It consists of two sets of scales; one measuring the practices of physicians and the other set that of nurses. A sample of 95 nurses and 94 doctors completed a test and retest questionnaire to establish validity and reliability. The results showed Spearman co-efficient for correlation $r = .42$, although a weak correlation it measured the existence, and reliability of Collaborative Practice Scales. It is a valid and reliable tool (Weis and Davis 1985; Alpert et al, 1992). It would have been informative for Alpert et al (1992) to illustrate how the tool was used to measure the two variables.

2.2.2 Summary

A number of authors in defining CCP have encompassed the term multi-disciplinary (Kanter, 1989; Hewiston, 1992; Finnegan, 1993; Lancaster, 1993; Hale, 1995; Ingram, 1995 and Luther and Crofts, 1997), whilst others refer to inter-disciplinary approach (WNB 1993, 1994). What has emerged is that there is a difference in that the latter encourages collaboration. Applying a symbolic interaction explanation (Blumer, 1996 cited by Porter, 1998) would suggest that human beings act towards things on the basis of the meanings that things have for them. It could be a description of what the phenomenon means to them. People give meanings to what is going on around them (Porter, 1998). Hence they generate discourse to denote their understanding of the concepts. Extrapolating from this view it can be said that, whatever label is used the same observations of the phenomena are acknowledged. Relating to multi-disciplinary/interdisciplinary

practices the authors employ the terms to denote the same phenomenon, of professionals working together in collaboration with patients, but this needs to be made explicit to reduce ambiguity.

Secondly, the literature in North America shows that CCP is an extension of the nursing process, a managed care process (Kanter, 1989; Hale, 1995; Luther and Crofts, 1997;) that is facilitated by the use of care maps, which provide a care framework. In addition the nature of the framework requires representatives of professional groups associated with to a particular diagnosis of disease to converge in an effort to provide continuous and co-ordinated care (Hewiston, 1992; Finnegan, 1993; Ingram, 1995).

Thirdly, there is a diverse use of the term 'unified record system' employed to denote the same process of using pathways. This use of a unified record system is thought to break interprofessional barriers (WNB, 1994; Rigby, 1994). In some situations unified records are referred to as care maps (Hale, 1995) or as a multi-disciplinary action plan (Alder et al, 1995). A Review of these publications reveals a theme that refers to the same process of documenting intended care events that have been agreed between the professional groups.

Fourth, CCP is a process that can be implemented in conjunction with any other managed care systems. Thus CCP is a process of structuring professional input to enable care to be delivered in a co-ordinated and systematic way.

Fifth, it is believed that CCP is patient-centred (Hewiston, 1992 and Finnegan, 1993) one would expect some indication as to what users think of the process, for example, their satisfaction level in respect of the care delivered through CCP should be elicited.

Although Ingram (1995) described implementation of CCP and sought patient satisfaction levels, no data were included. Lancaster (1993) did the same when she described CCP in an orthopaedic surgical context with patients who had had total hip replacement. The claims of positive benefits to patients are highlighted, yet no

conclusive supportive evidence is provided. Most of the publications are either theoretical discussion or anecdotal accounts of local knowledge about CCP (Scott and Cowen, 1997).

The definitions provided by different authors, although diverse in terminology, all seem to focus on the philosophy of bringing the professional groups together to decide on the care needed for the client group **without users**. The process of both collaborative practice and collaborative care encompass care activities that are symptom or diagnosis related. It is difficult to see how predetermined care pathways would work with MHS users. People experiencing mental health problems, although affiliated with the same diagnosis, may follow diverse pathways. It can be argued that it would be difficult to be precise as to the outcomes, simply because of the nature of, and individual reaction to, mental illness. An abnormal physiology diagnosis-related group would in most cases follow a more defined path, hence have more predictable outcomes related to care activities

2.3 Managed Care System:

In the literature review it became clear there is a close association between CCP and managed care, which is an organised strategy of co-ordinating care in a systematic and integrative way (Zander 1988). It has three components: care pathways, variance tracking and case manager (Hewiston 1992; Jones 1998). This is the concept of integrated pathways that is gaining popularity (Walsh 1997; 1998; Jones 1998; Currie and Harvey, 1998; Campbell et al, 1998)

The term clinical care pathway (also referred to as care maps, anticipatory recovery pathways, integrated pathways, multi- disciplinary action plans) details all interprofessional actions to be administered to a specific diagnostic related group for a predetermined period of time.

Variance tracking comprises auditing pre formulated care events and associated

interventions (Petryshen and Petryshen 1992). The case manager who at times is referred to as care manager, ensures that the pre planned interventions are being carried out to meet the predetermined outcomes (Jones 1998).

Managed care system is a broad term covering structural frameworks such as case management, patient-focused care, co-operative care and Planetree care.

2.3.1 Case Management:

The term case management has comparatively recently gained prominence (Bergen, 1992). It is a structural framework that organises patients' needs in a co-ordinated and systematic way, using a problem solving approach. Case management is an extension of primary nursing using nursing process and has the same features as CCP (Zander 1988). CCP can be used with case management as a way of planning integrative interventions to meet the needs of the users. This confirms that CCP is a process, but unfortunately the use of clinical pathways has led to a task orientated care (RCN 1992) and, apparently with no involvement of the user. It has recently become evident that there is a chance for the MHS user to be actively involved in the pathway (Walsh 1997; 1998).

The definition of case management is central to the de-institutionalisation policy that promotes independent living for users; it is therefore arguably consistent with the community care context. It seems to be commonly used in community mental health care; particularly in relation to care of the long term mentally ill to ensure that the individual MHS user gains access to various service and agencies (Shephard, 1990; Thornicroft, 1991). Conceptually, case management is based on the assumption that people have complex problems, and therefore, are in need of assistance in utilising the mental health care system (Onyett, 1992).

There appears to be no universal consensus about what constitutes case management and how it differs from other managed care systems. From the literature there is no difference identified. The framework of case management operates at different levels, and there is a diverse interpretation of what is involved.

Shepherd (1990) and Kingdom, (1992) point out some of the principles encompassed in case management. These include:

- Carrying out a comprehensive assessment of individual needs.
- Developing an individual package of care to meet their needs.
- Ensuring that the individual gains access to the appropriate service/resources.
- Monitoring the quality of service provided and liaison with service providers.
- Offering long-term flexible support that is adjusted according to the changing needs of the user.

The above principles provide guidance on how case management should be adopted. The role of users is not explicit yet the aim is to identify and meet their needs. In addition (Dustan 1990) points out different ways of providing quality care but fails to build in a mechanism to elicit users' views about the service.

MHS users' views regarding case management

A number of projects have been evaluated in depth but a majority emanate from the social service context (Bergen, 1992). For instance, in the Kent Community Care Scheme, a case study approach was adopted to describe and evaluate case management for frail elderly people. The findings demonstrated a high quality of care for the experimental group in comparison to the control group (Challis and Davis, 1985 cited by Bergen, 1992). There is no evidence of clinical pathways being used.

Cullen et al (1996) describes a study of MHS users (n=70) in an experimental design; a control and a case managed group. The participants are reported to have been dissatisfied with traditional approaches of care, so turned to case management. The MHS users who received case management demonstrated a high level of satisfaction compared to the control group. Twenty-two items altogether constituted the questionnaire. No details were included to indicate the process of questionnaire administration. Qualitative data supplemented the questionnaire, but no further data were given in order to evaluate critically the methodology and draw

significant conclusions. The researchers, however, acknowledge the limitations of the study, in particular, the sample size. Consequently generalisation to other populations within the mental health service is limited.

It could be argued that, because of the diverse interpretation of case management, the methodology employed might be problematic when replicating the studies. The satisfaction levels tend to be provider orientated with an incorporation of users accounts. Very often, the MHS users would not be aware of the standards expected of care (McIver, 1991; Avis, 1995). Furthermore Cullen et al (1996) could have explored the MHS users understanding or expectations of case management from their perspective and derive an operational definition understood by both professional and user.

In summary the literature has shown that case management could be used in a variety of ways, with different models (Thornicroft, 1991; Netting and Williams, 1995). The purpose of case management appears to be one of providing well co-ordinated, continuous care so that predetermined outcomes are reached within an appropriate time limit. In case management the concept of CCP appears to be the process that ensures negotiation and decisions about the care to be provided. However, the MHS users' contribution to CCP is not addressed and nor are the users' views sought about the benefits of using of clinical pathways. Gourney (1996) argues that although the MHS users, in some cases, are physically involved in the collaborative approach to care, their presence is but tokenism. They have no substantive influence on decisions made about their care.

2.3.2 Patient-Focused Care:

An extensive exploratory analysis of the traditional approaches to health care delivery reveals that the results showed some inadequacies in the management of resources. Subsequently, patient focused care emerged as an alternative to the traditional care delivery system (Lathrop et al, 1991).

Patient-focused care as a concept is based on a decentralised organisational structure in which resources are allocated according to patients' needs instead of

institutional requirements (Lathrop et al, 1991). The needs of the patient dictate the care strategies required as opposed to reflecting the needs and convenience of the provider (Porter-O'Grady, 1993). Five principles form the basis of the patient-focused care (Lathrop et al, 1991). These are to:

- Streamline and simplify documents, resulting in a reduction of the amount of time spent on paper work, thus increasing time for direct patient care.
- Place routine services close to the patient, in order to reduce time spent on pursuing various services that promote recovery of the patient, such as auxiliary services and transportation.
- Broaden caregiver qualifications by cross training. Through cross-training nurses for example can be certified to undertake simple auxiliary technical tasks such taking X-rays. In this way, numbers of staff interacting with patients is reduced, thereby enabling a quality staff-patient relationship (Morgan, 1993). Instead of two members of staff offering two different tasks only one would perform both tasks.
- Simplify the process of delivering care in order to reduce non-productive activities, for example, nurse transporting a user from one department to another for investigation, may result in quality time spent on direct care.
- Focus on patient population and reduce variability. Use of interprofessional integrated knowledge related to the patient population enhances responsibility for patient care with the consequence of high quality care.

The above principles when translated into practice highlight the significance of localising all the services around the patient needs. There is a general agreement that by adopting such a framework the care is streamlined and may be cost-effective. Incorporated in patient-focused care is the care protocol. Patient focused care is another framework that utilises collaborative approach to planning but the delivery of care is limited to a few health professionals.

The potential drawbacks associated with the clinical pathways in patient focused care are task-orientated care, driven by biomedical ideology. The Royal College of Nursing (RCN) 1992 expresses concern over the use of care maps asserting that their use is external to the needs of patients. But Morgan (1993) disagrees, pointing

out that the multi-disciplinary team continuously evaluates the care administered but the users' views are not sought as an integral part of evaluation.

Describing a study on patient focused care approach Morgan (1993) concludes that fragmented care is the drawback of the traditional approach of delivery of care. A patient-focused care approach was instituted utilising care protocols. Co-ordination of care, according to Morgan becomes the role of the care leader who may be a first level registered nurse, responsible for a group of 8-10 patients (Carlisle, 1991). The clinical manager, presumably the ward manager contributes to the care map. The user involvement is not explicit although there is a suggestion that the map is adjusted to reflect each patient's unique needs (Alder et al, 1995). Within the patient-focused care framework Porter-O'Grady (1993) reckons patients are active participants; however he does not provide any evidence or explanation of how patient involvement takes place. Additionally there is no apparent indication of whether the patient understands the concept of patient-focused care. It should be noted that the study referred to by Morgan did not take place within the mental health service.

Patient focussed care model appears to be used synonymously with 'patient centred', but there is a difference between the two concepts (Shearer and Gray 1994). It would appear that patient focused is more to do with structures centred on the patient whilst the latter are the processes individualised to meet needs of the patient.

Doubt is cast over the effectiveness of the involvement of patient as a member of the health care team because of this lack of any medical training (Gage, 1994). It could be argued that these concerns fail to acknowledge patients' own experiential knowledge of their illness (Clark 1987; Senior & Viveash, 1998). Health care professionals have no monopoly over health issues. The multi-disciplinary team has to accept a patient's sense of his/her reality, even if the team does not share the patients' perceptions.

2.3.3 Co-operative Care Model:

This became increasingly popular during the 1970s, as a means of curtailing care costs; co-operative care offers patients the opportunity to function with maximum independence within their medical limitations. Based on the self-care philosophy of Orem's theory, it provides both patients and their families the opportunity to participate fully in the decision-making and delivery of the care process (Weis, 1988).

It has been claimed that co-operative care promotes a positive message that individuals can be patients in hospital but at the same time assume a greater degree of responsibility in their care process. The patient manages her own care with the personal assistance of the family, with the multi-disciplinary professional team acting mainly as educators. Therefore, medical and nursing interventions maintain, restore and improve patients' ability to care for themselves (Weis and Ashikaga, 1988; Mullin, 1995).

The co-operative care approach operationally requires minimal nursing care to be undertaken by the patient or family. The patient may stay in hospital with another member of family or friend (Weis, 1988) usually referred to as the care partner. The patient has to be sufficiently able to administer care and to be actively involved.

'Patient's participation as a co-worker in a interprofessional health care system is essential if practice is to actively promotes well being' (McLeod, 1995; 332).

During hospitalisation the patient and care partner engage in various care activities of daily living, for instance, taking medication, bathing and making beds. Education and training of patients is essential either at group or individual level (Weiss, 1988). A Co-operative care approach, like any other delivery system, may not be appropriate to everyone. Certain criteria for suitability have to be adhered to (Grieco et al, 1990). For example the patient should not require direct intensive care.

However, not having a care partner does not necessarily exclude use of co-operative care approach. Nurses may give personal assistance as long as the individual is well enough to manage her care activities. This approach gives great autonomy and enables patient and family to have increased participation in the health care process (Wood et al, 1988).

Co-operative care has been heralded as having wide reaching benefits to patients. These include, in summary:

- Increased patient and family knowledge of care interventions (Weis, 1988; Wood et al, 1988).
- Adherence to medical and nursing intervention (Chwalow et al, 1990; Grieco et al, 1990).
- Use of appropriate self-management strategies (Chwalow et al, 1990).
- Enablement of an easier transition from hospital to home (Weis and Ashikaga, 1988).
- Promotion of active patient participation in decision making (Weis, 1988).
- Increased patient and family satisfaction levels (Grieco et al 1990).

It would appear that the user is involved actively in the decision-making and is empowered to manage her care. The literature reports a high level of satisfaction among patients and family but no detailed information is available as to how the users' views were sought about the process itself, or their understanding of the co-operative care approach. On the other hand it could be claimed that the voluntarily participative nature of the care delivery system would enable the users to be conversant with the co-operative care approach (Grieco et al 1990). The notion of family care in hospital may be threatening to staff. Conversely, the approach could be said to be consistent with the New Right ideology (Allsop, 1995) with its emphasis on individuality and responsibility over one's own health.

2.3.4 Planetree Care Model:

The planetree care approach fundamentally resembles co-operative care approach in that it emphasises education of patients. Surprisingly Banks et al (1995) claim that the Planetree care model differs from other models of care delivery because of its focus on educating patients but this is true of co-operative care. Care partner non-involvement distinguishes planetree from co-operative care. The Planetree model is believed to respond to the needs of the patient who wanted to take a more active role.

“People want to share the responsibility of their care. The time has come to involve the patient as a full functional member of the interdisciplinary care team” (Gage, 1994; p. 27).

This is the first time that there has been an explicit reference made to the patient being part of the care team. Co-operative and planetree care approaches to care delivery allow users to have a degree of autonomy.

2.3.5 Summary of Managed Care System:

The review of literature has shown how managed care systems developed as a response to the demand to provide high quality care that is cost effective (Hale, 1995). Commonly found in all the modes of care delivery (case management, patient-focused, co-operative care and planetree) is usage of care maps that structure the care. It also appears to bring together the health care professionals to plan the clinical pathways (Hale, 1995; Ingram, 1995; Jones, 1998). Any deviation from the normative set of activities is treated accordingly resulting in the review of care maps. The concept of care maps is explicit in some studies while others are not so clear, for example, in the co-operative care system. CCP can take place within any of the previously discussed frameworks. However, the case management system appears to be commonly employed in mental health care setting (Jones 1998).

2.4 Decision Making:

MHS users views about decision-making

Increasingly user involvement in decision-making is becoming more usual. The impetus arises from successive government initiatives (Working with patients, 1989; Caring for people, 1989; Involving the public, 1998 and Putting patients first, 1998). User involvement at both macro and micro level is being sought. User movement groups have tended to highlight the importance of representation at service organisational and planning level (Epstein and Oslen, 1999).

The emphasis on user involvement is central to any patient-orientated service. However, some authors are sceptical of the notion, arguing that where user involvement in decision-making is implemented it tends to be merely tokenism (Campbell, 1993, Beresford and Croft, 1993; Gourney, 1996; Epstein and Oslen, 1999). There is no formal structure for consultation in seeking users' views at every stage of care.

Reviewing literature of patient participation in a psychiatric care setting Glenister (1994) found that carers and users want to be actively involved in deciding care rather than it being seen as tokenism. This is in contrast to the notion that MHS users adopt a passive role. There is no indication of whether the MHS users' conceptual understanding of decision-making was consistent with the health professional's (Glenister, 1994). Decision-making can range from involvement in delivery and evaluation of care to simply consulting a user on a specific issue. Brearley's (1990) extensive literature review of patient participation concluded that the concept of patient participation meant different things to different people. In essence, decision-making is more than being simply consulted about a health related issue; it encompasses having a voice and being heard (Bishop and Scuddler, 1985).

Different conceptualisation of user participation in decision-making exists among health professional and users. Henderson (1998) describes a study, in which a sample of 33 nurses and 32 patients each gave an interview of 60 minutes duration, which was tape-recorded. The rationale and objectives of the study are clearly expressed. The sampling procedure comprised a selection of informants

who were knowledgeable about the topic and also who were willing to share their experiences. The sample population came from medical and surgical wards in one district hospital. Data analysis produced three emergent categories:

- Inclusive participation
- Partial participation
- Exclusive participation

The inclusive participation category encompassed positive views about user participation in all stages of care and being part of any decision-making process. Perception of both patients and health professionals indicate a strong suggestion that involvement in decision-making means being vocal and listened to. The comments of a nurse interviewee demonstrated a conceptual shift embracing patients' active participation in care. In order to participate fully, information should be accessible to patients to enable them to make informed decisions (Salvage, 1990).

In the partial participation category, it is assumed that there is lack of user participation because users have no medical knowledge. The users give prominence to the role of the health professionals as experts and seemed to accept that their role was one of being co-operative due to lack of essential knowledge.

The exclusive participation category patients seek to stay in the professionals' "good books" to avoid being labelled as 'bad' patients (Kelly and May, 1982) or they may feel intimidated. Therefore they make no attempt to have a say. Of the three forms of conceptualisation, partial participation appears to be the commonly favoured style of interaction. The exclusive participation occurs to a lesser degree. In contrast the inclusive participation, which is the ideal and a desirable mode, is scarcely found in practice (Henderson 1998).

Demonstrated in the study is the dichotomy of perception between the health professionals and the patients related to participation in decision-making

regarding their care. Despite users being urged to take an active role in decision-making they felt unprepared due to lack of medical knowledge. Although this study was carried out in the medical and surgical wards the findings can be related to MHS users who are attending day care facilities. This is to do with users interacting with health professionals.

Biley (1992), using an inductive modified grounded theory approach, identifies some determinants that facilitate patient participation in decision-making about their care. Eight patients aged between 21-75 years of age were interviewed, 10 days after discharge from hospital. The findings revealed that patient participation in decision-making is determined by their position in the wellness-illness continuum and additionally, organisational constraints can hinder patients from actively participating. The author concluded that, although patient participation is desirable and is being positively encouraged, there is, however, absence of empirical evidence to support claims about the willingness of patients to be actively involved in the decision-making process.

The results have to be read with caution. The findings suggest that the patients do not wish to participate in their care. However, the study does not appear to take into consideration of other extraneous variables that may have an influence on the extent of patient involvement. For example, educational background, or occupational status, which would indicate the level of knowledge and understanding, and influence the desire to participate. Similarly any previous health care experience could also affect the strength of feeling related to their involvement. Organisational constraints are reported to preclude patient participation but the author's failure to identify the form of the constraint that would be implicated and the type of nursing practice involved, does not allow the reader to critically evaluate the effects.

Wilson-Barnett and Fordham (1982) cited in Waterworth and Luker (1990) disagree with the Biley (1992) view that there is lack of evidence to support claims about patient participation in care. They assert that there is evidence to substantiate that active participation leads to improved outcomes. Neither of

these claims is substantiated.

Biley (1992) acknowledges the limitation of his study. It does, however, nonetheless extend the knowledge about certain attributes that may or may not encourage participation. The users' involvement in decision-making regarding their care will depend on how the users perceive their relationship with the health professionals. Biley does not provide details of how the data were analysed, for example there was no explanation regarding the saturation of categories (Field and Morse, 1985). The categories appear to arise from the patients' own words. The sample was so small that it is probable that the categories did not reach saturation.

Investigating 516 MHS users' experience in mental health hospital Roger et al (1993) report on how the MHS users were dissatisfied with an absence of collaboration with health care professionals regarding treatment. An operational definition of treatment would have been valuable because users often consider treatment to consist of only medical care as opposed to any therapy that promotes their recovery. Users may require more information to make informed decisions. Iskander (1999) endorsed similar opinion although argues from a different perspective, that of a consumer.

Another study by Caress (1992) used a convenience sample of patients undergoing renal dialysis. Data were collected through five sets of cards in which a patient had to pick a single card that denoted his/her perception of what constituted an active role in treatment decisions. The findings indicate that the single role most identified in the set of cards was collaboration and the majority of patients preferred to adopt a passive role. In addition older patients chose to be passive recipients of care.

These patients were receiving a renal dialysis, a specialised field that might have encouraged the inactive role. The author concludes that patient participation in decision-making is "not universally welcomed by patients themselves" (Caress, 1997: 45). The results have to be read with caution. They might have been

influenced by the physical state of the renal patients who are usually very ill and feel dreadful, which the study does appear to acknowledge.

The extent to which MHS users would wish to be involved in decision-making

The literature is scarce in relation to published research related to eliciting how much MHS users wish to be involved in decision making regarding their care. Decisions related to their care have been perceived as being dominated by the medical model (Roberts and Krouse, 1990). The conceptual shift towards more user participation in decision-making appears to be becoming the rule than the exception especially because of government initiatives (Patients Charter, 1992, DoH, 1994). Patient collaboration is being recognised as an ideal outcome as it enhances users' responsibility and commitment to individuality (Trnobranski, 1994). The concept of patient collaboration in decision-making about their care has not been adequately examined or clarified (Cahill, 1996).

Following a small-scale (n=12) study in a medical setting Waterworth and Luker (1990) investigated patient collaboration using a grounded theory approach. Employing a conversational style interview method of collecting data, they identified an emergent theme in patient perspective as 'toeing the line'. Behaviourally, the patients were said to be pre-occupied with doing everything possible to be good patients and stay out of trouble, rather than actively participating in decision-making concerning their care.

Caution has to be taken with results. Methodologically, insufficient information is provided about the interview process, except that it was an informal interview. No justification is provided for convenience sampling; it appears to be the most commonly used method in nursing research despite its weakness in establishing validity (Polit and Hungler, 1997). In addition, reference is made to grounded theory, but no details are provided about the thematization procedure and how the categories were formulated. Biographical details of the patients, which may have influenced the results, were excluded. Notably this did not have MHS users but none less it is interesting and significant. The number of those who 'toed the

line' is not provided. Albeit a small study, the message is clearly warning the health professionals to be cautious when dealing with patients. In their desire to encourage patients to participate actively, there may be an unwitting tendency to coerce them into participation. The patient may be participating purely for fear of being labelled unpopular (Stockwell, 1972; Kelly and May, 1982).

To what extent MHS users would wish to be involved in decision-making is not explicit in the literature. Means (1992) suggests two possible ways of involving user participation: the democratic and the market approach. First, the democratic approach empowers the service user to take more responsibility over care, thereby enabling them to have a say in the delivery of care and running of the service. In that way the MHS user has control over the care administered. The user can dictate the extent of participation in decision-making at every stage of the care process.

Secondly, in the market approach, the MHS users are given the choice between alternatives and are given an opportunity to leave the service if it is not effective or efficient. In other words, if the users are not satisfied with the delivery of care they may decide to leave the service. This is not always possible because of their vulnerable position. Moreover very often the users are not informed about the criteria of expected standard of care (Avis, 1995).

Influence of gender, age and nationality on decision-making

Younger age groups are more culturally inclined to express their needs than perhaps the older group who tend to be conservative and hesitant when it comes to authority and status. This is evident in a multi-national survey investigating the professional and patient relationship in decision-making (Kim et al, 1993). The findings revealed that one third or more of patients in all countries at least preferred to be informed of decisions made for them. In Japan and Norway the subjects believed that it was their right to have a joint role in the decision-making process, whereas Finnish patients concurred with the statement that patients should be excluded from the decision-making.

Furthermore, the younger male subject, regardless of country of residence; rejected authority and demanded the right to make decisions. The authors concluded that in order for patients to participate actively in decision-making process a change in the fundamental 'beliefs and ideologies are required' (Kim et al, 1993, p 399).

The reader, however, is left wondering about the areas of focus in the survey's questionnaire as no further data were provided for clarification. The design is not explicit. Neither is the response rate addressed considering the geographical area covered is so vast. It could be argued that the health professionals may coerce conservative elderly patients even though this may be done unwittingly (Waterworth and Luker, 1990). The study fails to acknowledge that culturally, patient non-involvement may be an accepted norm. There appears to be a strong suggestion that some users are not so keen to participate in decision-making about their care (Trandel - Korenchuk, 1982; Anderson, 1988; Caress, 1997).

Determining what role patients preferred to undertake, Strull et al (1984) surveyed patients (n=210) receiving out patient care for chronic hypertension. Physicians (n=50) also completed a questionnaire. The findings indicated an incongruity between health professionals' perception of how much patients want to be involved in decision-making; 63% of patients stated that they wanted the health professionals to make decisions embracing all available information about the treatment. Thirty seven per cent of patients compared to 80% of clinicians reported that patients participated in decision-making to some extent. Nineteen per cent of patients expressed a wish to share equally with the clinicians. One third of patients preferred the clinicians to make all decisions but to take into consideration their opinion. Another 47% of patients felt that health professionals took decisions without consulting them.

A dichotomy emerged between user perception and that of health professionals, which could be attributed to different conceptual understanding. In response to "what role do patients prefer to play?" some of the patients did not want to play any role in actual decision making yet 78% of clinicians believed that patients want to be involved to a certain extent. In contrast only 53% of patients actually

wanted to be involved.

This, however, is in contrast to Biley (1992) who found that patient participation in decision making depended on how ill or well the patient was. Patients with chronic problems would be expected to participate more in their care in order to self-manage their condition. The findings need to be treated cautiously as no reference is made to personal knowledge of the patient. Notably, however, the data are old. This could reflect the trend in health care system at that time that patients were expected to be passive recipients of treatment.

Strull et al (1984) fail to indicate the other professional groups that took part in the study. If only doctors participated, then, inevitably, the users would feel deficient in medical knowledge to make informed decisions. This is why Rowley et al (1994) urge that the health professional should use lay language to enable the users to understand what is happening to them and to help them make informed decisions.

Information is power and users need it. Investigating views of MHS users regarding their treatment, Ballard and McDowell (1990) found that 30-40% of patients had not received sufficient information to enable them to make informed decisions. This raises the speculation that had information been available the level of participation would have been high (Glenister 1994) and MHS users would be active participants in deciding their care (Eisenthal et al 1983). No empirical data to substantiate this claim is offered.

Exploring the introduction of lay participation in care, Myer, (1993) through action research, found that health professionals were sceptical about lay participation. They perceived lay participation in care as disruptive to their routine and ever increased heavy workloads. Myer found that lay participation was limited. In conclusion, the author acknowledges the need for cultural change with full professional commitment to the concept of decision-making.

Myer (1993) remarked on how users had no access to their notes or care plans,

when access is something that is seen as desirable. The patients complained of lack of information. Decision-making is not conspicuously expressed but it can be said to be inherent in care delivery. Parahoo (1997) advises the importance of operationalisation of concepts, to make them comprehensible. The reader needs to be aware of the precise meaning of these terms in order to make a judgement on the worth of the findings (Rees 1997). The term lay participation could have been defined, as there appears to be no consensus on the application of the term into practice.

Ways in which users could be involved in decision-making.

Ways of involving users in service planning and organisation are extensively documented. Examples include consumer consultancy, consumer advocacy, trainers and consumer case managers; these are just a few ways of enabling the users' perspective to be reflected at the organisational level. How the professionals engage users in decision-making process as opposed to what amounts to little more than a 'lip service approach' (Lindow 1990) must be examined.

Ralph and Muskie (cited in Epstein and Uslen 1999) list a few suggestions: the professionals should listen to MHS users without making a judgement based on their mental condition. Health professionals should be sensitive to their own and others stigmatising language as this causes suspicion that may interfere with the development of a relationship. Furthermore there should be acknowledgement of MHS users' contribution to decisions and credit given publicly. These are good ideas but fall short of stipulating what strategies can be used to involve actively users in decision-making process at a clinical level. Some of the suggestions can be applied at an individual personal level. The most important element of care that appears to be emphasised in the literature is the need for health professionals to listen to MHS users' views and take them seriously (Epstein and Oslen, 1999).

There is scarcity of ways on how to enable decision-making in MHS users become a reality, Meyer (1993) and Gibson (1991) suggest a change of culture. Presumably they mean that the culture of delivering care in the clinical practice

setting should change in keeping with societal expectations. This would involve changing from what Goffman (1968) described as 'total institution' where the user's behaviour was moulded by the institutional demands, rather than by his needs.

The literature indicates that most studies that have investigated users' perceptions of some aspects of care have tended to utilise a quantitative approach, a questionnaire being the chosen data collection method (Holloway, 1988; McIntyre et al, 1989; Ballard and McDowell, 1990; Roger et al, 1993). Qualitative research, on other hand, employs an interview format (Teasdale, 1987; Biley, 1992; and Morrison, 1994). What is noticeable, however, is that where global questions are utilised the results indicate satisfaction of care. Conversely dissatisfaction when personal questions are used to obtain personal views. Most questionnaires are professionally orientated not always grounded in the user's value or beliefs (Avis, 1995).

It is clear also that there are very few studies pertaining to MHS users giving their views about decision-making processes or their conceptual understanding of the concepts often associated with care processes. The main difficulties are:

1. Ascertaining what CCP means to the users of mental service.
2. Calculating to what extent they would like to be involved in decision-making.
3. Finding out what exactly is meant by them being involved in decision making.
4. Determining the ways that can be adopted to actively involve users in decision-making.

2.4.1 Summary of Decision-Making

The literature review reveals various studies investigating experience of users in decision-making but in different care settings; surgical (Waterworth and Luker, 1990; Biley, 1992) medicine (Morrison, 1994) and mental health acute care,

(Lovell, 1995), whilst some have focused on the satisfaction levels of the services they have received (McIntyre, 1989; McIver, 1991; Roger et al, 1993;). It is noticeable that there is very little research pertaining to MHS users' views about their role in decision-making concerning their care. In addition there is lack of firm evidence to indicate in what ways the users would like to be involved in deciding their care. Only one study was found to be addressing CCP in mental health service hence the reasons for including studies from other health care settings.

It seems from the literature that MHS users would wish take an active role in decision-making about their care (Glenister (1994). However, some individuals do not want to take part in decision-making (Trandel-Korenychuk 1982). The literature is not conclusive as to what is best for users in the face of the call from government initiatives to involve users (Myers, 1996; "Involving the Public", 1998). It is not a matter of users not wanting to partake in decision-making activities, but only that there is no evidence to support this contention that the MHS users want to participate (Tmobranski, 1994). This stand reflects the broad view of patients who are not MHS users. It could be argued that in striving to conform to the philosophy of participation, unwittingly, the health professionals might compel users to comply. This contradicts the idea of personal choice and fails to take into account other variables that have being reported to influence participation in care.

2.5 Social Environment

Glenister (1994) recommended that future research should examine the role of social environment because that influences the outcome of patient collaboration. The definition of care has tended to be applied within the medical psychiatric ideology that claims that health professionals know what is best for the user (Pritchard, 1986). MHS users are viewed as incapable of making decisions about any aspects of their care because of their mental health status.

The social environment of the care setting has been reported to foster

dependency, lack of autonomy and to be paternalistic in nature (Beresford and Croft, 1995). Such conditions may have provided the health professionals with a secure power base. The patients may be disempowered and perceived as passive recipients. Goffman (1968) describes the environment then as 'total institution'. Since Coffman's time then there have been changes in the health care system but Morral (1996) maintains that the patients are still passive and unquestioning of the care they receive. They are without a voice in the delivery of care and are consequently exposed to routines of the care setting.

The relationship between health professionals and the MHS users can be said to be one of parent-child rather than adult to adult (Weaver and Wilson, 1994). Health professionals may use the relationship as a means of maintaining social control, and assuming all authority for care (Hugman, 1991). Cavanagh (1996) echoes the same sentiments stating that the health professional have power and authority to influence the user's life.

Ultimately the users may be said to lose control and freedom (Favod, 1993). Government policies seek to ensure that the traditional imbalance of power between professionals and users is significantly altered, where possible (Myers, 1996). Such an unequal relationship may have a profoundly damaging effect on the individual's contribution to care (Brody, 1980). All too often the staff decide what is best for the service user under the guise of implementing a helping process (Morrison, 1994).

The whole experience of being in a mental health hospital would appear to alter the users' social role and make the individual give up responsibility, in turn losing freedom to control own care. The individual may become subservient to the demands of the professionally orientated social environment. Reflecting from her experience Chamberlain (1988) feels that hospitalisation promotes dependency with very little participation in decision-making, with MHS users becoming indecisive and at worst doubtful of their own judgement. Lindow (1990) also appears to be of the same opinion, relating to how physical treatment was imposed on her whilst receiving institutional care. None of these authors indicate

the kind of social environment that they would have found helpful in meeting their needs. Lindow (1990) does not say under what circumstances the physical treatment was imposed on her. It would have been valuable to learn from her what she would have considered to be the best strategy. What can be inferred from her assertion is that no choice was offered to her. There is no mention of discussion having taken place and her views were not taken seriously.

The MHS user wishes to participate in a social environment that promotes their individuality (Myer 1990). They tend to gain a sense of freedom and control in those activities that they were well informed of and which were not professionally instigated (McIntyre et al, 1989 and Sharma, 1992). Such simple issues as taking a decision related to going for a walk, or receiving visitors were valued more than attending a ward round.

Health care professionals should begin to foster a sense of responsibility and an attitude of independence in users. Hierarchical forms of professionalism undermine the “personalised knowledge” of the users. Horsfall (1997) believes that psychiatric epistemology somehow discourages the acknowledgement of users’ own expert knowledge about their condition. When users’ opinions are sought, they usually complain of the health professional discounting their views. Use of professional language only exacerbates the impersonality of the relationship (Roger et al, 1993) and thus it disempowers the user. Lougulin (1993) gives further evidence of how professional language discourages full participation in care. Furthermore patients did not follow the process of ward round because the professionals tended to use unfamiliar language (Busby and Gilchrist 1992).

A democratic professionalism that requires different patterns of relationship between health professionals and users could be considered. In this way a change of practice would address ways in which service users can be enabled to exercise their knowledge. Trandel-Korenhunk (1982) cited work of Szaz and Hollander (1956) regarding models of social environment. The three models are:

- **Activity-passivity model.** The health professional assumes full responsibility for identifying goals and instituting care strategies to meet the health-related problems. The users adopt a passive role. It can be argued that some users according to Anderson (1988) do not wish to be involved in any care decisions.
- **Guidance-co-operation.** This model remains dominant in the present day delivery of care. The users co-operate with all the instructions and directions offered with regard to their care. It can be argued that in this model the health professionals attempt to socialise users into an ideal person.
- **Mutual participation.** This model requires a social environment that encourages equal partnership, mutual respect and both participants engaging in a meaningful dialogue. It could be said that it is not always easy to express medical terms in lay language and that may, at times, impede active user participation (Lougulin 1993).

The notion of users having an input in their care plan is viewed as not only desirable, but also essential to be encouraged. Essex et al (1990) carried out an 18-month study of 84 MHS users who suffered from schizophrenia, had access to their personal records, and were receiving care from the G.P rather than hospital based physicians. The purpose of the study was to find out the perception of the MHS users about seeing their records. Eighty percent of users liked the idea of seeing what was written about them and felt that they were in control of their treatment. Caution, however, must be taken as a G.P rather than a psychiatrist cared for these users. Therefore, it can be said that the findings were not representative of the population of users with mental health problems who are cared for by psychiatrists. The study gave MHS users their health records and subsequently reported this arrangement as active participation in treatment, but there is no data available for inspection to substantiate users being actively involved in the full sense of the process.

Simpson (1997) describes how informal carers perceived the record keeping to be beneficial and felt more empowered and valued by the health professionals. Both

health care professionals and carers of dementia sufferers contributed to the keeping of care plans. No details are available to show whether the carers had any understanding of care plans although written consent was obtained from the carers

From the literature it appears that one way for users to be involved actively in their care and supported by social environment is to have a shared record keeping system. Allowing users to see what is written about them can be another way of empowering them (Simpson, 1997).

Research methods found to be used in the studies reviewed

Qualitative research has been the chosen research approach investigating peoples' experience because it provides a way of capturing human meaning of the lived experience (Field and Morse 1996). In a descriptive survey Wainright et al (1988) used a questionnaire to obtain views of 115 service-users on aspect of care in a day hospital. Strull et al (1984) used a survey, as did Roger et al (1993) to investigate the user's experience in a psychiatric hospital. No rationale is provided for using a survey approach against any other method. Although the study does not state the rationale for selecting this approach the sheer size of sample population (n=516) requires a survey method. While investigating the views of the users about mental health service McIver (1991) used a survey, as did McIntyre et al (1989) in their study of what psychiatric patients really want. They employed an exploratory survey, and interviewed n=117 patients. The interview schedule consisted of 10 questions on a Likert scale that required a judgement of items in relation to helpfulness. On the basis of these studies reviewed, a survey appears to be the preferred method.

2.6 Conclusion of the Literature Review:

The literature pertaining to decision-making in service-users has predominantly come from the studies related to medical and surgical care settings (Strull et al, 1984; Waterworth and Luker, 1990; Biley, 1992; Morrison, 1994 and). Very little is known about the MHS users' views regarding their participation in

decision-making. What is explicit is that the users would like to be active participants (Glenister 1994). There is no suggestion about the strategy to be taken to ensure a genuine participation.

Conflicting information emerges in the literature, some authors stating that users want to be involved in decision-making (Brody, 1980; Gibson, 1991; Glenister, 1994; and Simpson, 1997). Conversely, there is evidence to suggest that whether patients wish, or do not wish, to participate, constitutes taking part in decision-making. A number of studies reveal that those users may behaviourally avoid being labelled “bad patients” (Kelly and May, 1982), instead adopt a ‘toeing the line’ stance (Waterworth and Luker, 1990). Typically, according to Morrison (1994) patients are reluctant to criticise the staff. It is difficult to establish whether or not users wish to be involved and if so, to what extent. Furthermore the review has revealed some difficulties in the way users can be integrated into the decision making process.

The literature review has shown that the concept of participation in decision-making has received great prominence, ranging from small-scale studies to personal anecdotes. The difficulty with the concept is that it covers a wide variety of approaches (Brearley, 1990). Similarly, asking a patient's name or questions relating to their health, without the patient dictating own views could be construed as participation. It can be concluded that the definition of patient participation has not been clearly defined. In some cases the concept is employed interchangeably with patient collaboration (Jewell, 1994; 1996).

Very little research is available indicating users' views on social environment yet there is general agreement that the collaborative process occurs in a caring environment where both users and professionals interact. Clinicians appear to find the ideas of patient participation in decision-making uncomfortable (Simpson, 1997). Traditionally the health service has promoted professional power and control, which has disempowered and not valued user's experiential knowledge (Wilson, 1995; Senior and Viveash, 1998 and Speedy, 1999).

Another dimension of social environment is the accessibility of care plans. This is seen as another mechanism of empowering users and valuing their contribution. But caution should be taken and professionals must treat each person on an individual basis, as there is no evidence to suggest that all users wish to participate actively in care by examining their records.

The literature is devoid of users' views about CCP and their opinions about the social environment. It is from this premise that the current study included social environment and sought the views of the users to determine what factors influenced or hindered decision-making in a collaborative process.

Chapter Three

- Methods and Data Collection
- Survey Design
- Sample
- Pilot Study
- Distribution and Return of Questionnaires

CHAPTER 3

METHODS AND DATA COLLECTION

3. Introduction

Method is the tool of the researcher who uses it as s/he sees fit in pursuit of the extension of knowledge, and also according to available resources, and research conditions, and questions (Sarantakos, 1994: 56).

This chapter focuses on the design employed to obtain the data to address the research questions. The questions asked are: **what are the views of the users and health professionals regarding CCP in the mental health service? What does the literature say about user term collaboration in the mental health context?** In order to answer the research questions objectives were formulated to inform the type of data required. These were to:

- Determine users' understanding of the meaning of CCP
- Elicit the views of the users about their role in decision making regarding their care plan
- Identify whether and to what extent they wish to be involved in decision making process regarding their care plan
- Find out how decision-making can take place to enable a strategy that reflects their wishes.
- Ascertain whether social environment is conducive to CCP.

A descriptive survey study that uses both quantitative and qualitative approaches to obtain the data to answer the research questions is presented in two phases. The first phase describes the subjects, the tool used to obtain the data and the procedure for applying the tool to the subjects and analysis and the analysis of the data obtained. This is followed by interviews used in conjunction with critical incident technique (CIT) to illuminate further the conceptual understanding of CCP. To address the objectives of the study the following procedures have been adopted to avoid asking the MHS users about a phenomenon not commonly applied in practice. The author undertook three steps leading to collection of

data.

First, prior to the commencement of the study, electronic and manual search of literature examining the concept of CCP was undertaken. It was carried out in an effort to determine the definition, the process and the role of the MHS users. At the time, there appeared to be a scarcity of empirical studies in which the concept was examined within the mental health care system. However, drawing on the literature from American health care, the term appears to be commonly employed to refer to a joint practice of planning care between physicians and nurses.

For the purpose of this study collaborative care planning was defined as

“MHS users working together with health professionals to decide on a care plan in a mutually understanding relationship where each person’s contribution is respected and valued.”

Secondly, in order to ensure that users were asked about a concept that they had been exposed to in practice, the author spent two months making informal inquiries in the care settings to establish the extent of CCP that was currently taking place and the involvement of users. This phase of the study centred on two community mental health centres. The informal inquiry revealed that user involvement in a multi-disciplinary context was minimal: participation of MHS users in collaborative meetings was not the rule but rather the exception. The multi-disciplinary meetings seemed to decide on the MHS users’ progress or referral but rarely did the MHS users participate in the decision making process and for that reason it was decided against including users from the community mental health centres.

However, contact with the day care units revealed that the concept of CCP was being applied in practice. This was also true of other in- patient care settings. It was noted that each day care unit had a philosophy of care that emphasised the need to value and respect users as individuals. The service prided itself in being multi professional in nature. The health care professionals worked together to plan care and they confirmed that they involved the MHS users in the care planning process. Therefore, it was felt that it would be possible to elicit the

views of the users attending the day care facilities.

3.1 Ethical Consideration:

Ethical approval was sought from the District Ethics Committee that required certain conditions to be fulfilled before the study could be considered. These included development of an MHS user consent form, an example of the data collecting tool and letters of approval from the responsible consultant psychiatrists and unit managers. Assurance was given that no repercussions would follow any refusal to participate. Physical harm was not anticipated, but perhaps psychologically the research might raise undue expectation of immediate influence on the subsequent care that MHS users may receive. This was dealt with through explication of the purpose and the procedure of the study.

There are ethical implications at every stage of the research process when conducting research; respondents need assurance of confidentiality that any disclosure of any information is respected (Rees 1997). The consultant psychiatrists and unit managers gave permission for the study to proceed as long as it met the committees' ethical requirements. The process of negotiating access to the users took place over four months in an attempt to meet these ethical conditions

3.2 The Research Setting

The quantitative study using a questionnaire to gather data took place within two mental health day care facilities, each providing a multi- disciplinary service. The two units were similar in terms of their role and functions and were said to be practising CCP. Both units provided assessment and treatment to the members of the community with mental health problems. In addition some in-patients from the adjacent acute wards attended the day care facilities as a way of facilitating their early return to the community. Those users with organic mental health problems who had their own specialist service were excluded from the main

study, as were in-patients.

The MHS users attended from the community and their attendance varied according to their health needs. Their attendance was staggered, with some of the users attending once a week and others on daily basis depending on their care plans. The day care units run from Monday to Friday 9.a.m to 4.30 p.m.

A convenience population that consisted of MHS users and the health professionals working in the units was included. Inclusion of the MHS users was based on the premise that, because they were day-patients, they would be free to express their views without perceived threat of compromising their care. At the time seventy users were attending day care facilities for a range of therapies. Their names, together with their pattern of attendance, were clearly displayed on a whiteboard located in the manager's office. Attendance was also monitored daily through a manual register.

3.3 Comparisons between Qualitative and Quantitative Approach

The choice of research approach was influenced by the fact that the researcher required numerical data to demonstrate whether or not the MHS users were aware of the concept of, and to determine the state of knowledge about, CCP (Burns and Grove, 1987). The conceptual framework guided the formulation of the questions that would address each component of CCP; there was no opportunity for the individual MHS user to express his/her answers in own words beyond the options already provided in the questionnaire (Rees 1997). The research strategy was planned before the commencement of the study. It was imperative that the researcher had a prior knowledge of the type of data required to address the research questions and how the data would be analysed.

By contrast the qualitative method is associated with the interpretative perspective and gathers information of individual experiences (Field and Morse, 1985) obtained through verbal answers (Rees, 1997). The original intention was that the information gained would inform the development of an appropriate tool

to measure the extent of collaboration within a care setting. The qualitative approach seeks to ascertain the MHS users experience of involvement in care. In that respect the quantitative approach was limited. To capture the experience of the MHS users related to CCP, qualitative approach using interviews would give insight into how the users are involved and constrains in care planning. With that in mind the third stage of the study incorporated critical incident technique (CIT)

The collection of data was extensive and would cover a wide geographical distance, and the selection of the sample population can afford a degree of representativeness (Rees, 1997). Generalizability is low in the qualitative approach but there are means of improving it. One way is the use of purposive sampling with stringent parameters (Silverman, 2000). In addition, if the researcher produces full explanations of the research process, that may strengthen generalizability (Mason, 1996). Lastly a deductive approach to investigation is employed in quantitative studies whereas the generation of concepts or theories emerging from the respondents' responses is associated with a qualitative approach. So from this it can be seen that both approaches have certain strengths and therefore complement each other.

Some commentators distrust the quantitative approach because it may treat respondents merely as sources of data (Carr, 1994). In a qualitative approach the researcher and the respondent spend more time together. The data are said to be potentially honest and valid (Brynman, 1988). This is not always the case, as the interviewee may not be inclined to disclose very sensitive material in an interview (Babbie, 1995). Conversely this interactive relationship may produce a 'pseudo therapeutic alliance' with the researcher entangled with the respondents, resulting in difficulty in isolating the researcher's experience from that of the respondent.

3.4 Survey Design

A survey design was utilised to gather and organise the appropriate data (Devaus, 1991) as, such a survey is appropriate for descriptive and correlational studies

(Parahoo, 1997). Thus this study is a descriptive survey as opposed to correlational study that aims to establish some link between variables without introduction of interventions, whereas an experimental approach requires an introduction of a variable and measurement of its effect on another variable (Field and Morse, 1985). The current study, although descriptive in nature, does implicitly determine a link between respondents' views and their demographic data. This may indicate whether what the users say might be influenced by their age, for example. The purpose of a survey approach is to generalise from a sample to a population in order for inferences to be made about some variables or characteristic of the population (Babbie, 1995).

The data were collected from the respondents to determine their views and opinions about the care approach to working together with health professionals. As a particular design it provides the approach to be pursued in both collection and analysis of data (Fielding, 1993). It is essential to utilise an effective design in order for the results and conclusions to be meaningful and useful. Commenting on the methodology when involving MHS users McIver (1991) states that sufficient precautions need to be taken by asking the right questions, and in the right manner.

The descriptive survey approach is particularly useful when examining a new phenomenon (Babbie, 1990). This was true of the present study, as the aim was to describe the views expressed in relation to CCP. As previously stated, at the commencement of the study there was a little available anecdotal information that related to the implementation and benefits of CCP (Finnegan, 1993).

3.4.1 Rationale for Choosing the Survey Approach.

The rationale for using the survey approach is three fold. First a number of studies within mental health context employ the survey approach in eliciting the

perception and attitude of users about some aspect of care they are receiving (Raphael, 1979; Holloway, 1988; Ballard et al, 1990 McIver, 1991; Roger et al, 1993). It has been shown to be creditable insofar as obtaining the relevant information to address the objectives of the studies. A second reason for utilising a survey approach was that it was economical both financially and in time scale allocated to conduct the study particularly as it was cross-sectional. In a cross sectional study information is culled at one point as opposed to the longitudinal strategy where data collection spread over a longer time (Fielding, 1993). Thirdly there is also a rapid turn around of data collection because the author distributed and collected the questionnaires (Creswell, 1994).

3.4.2 The Limitations of the Survey Approach.

Data are superficial and incapable of getting at the meaningful significance of social action. In addition, information obtained through a structured questionnaire format is relatively superficial and the researcher cannot understand how the individual arrived to a certain opinion (Polit and Hungler, 1997). The survey method can exert an enormous demand on personal time especially during the formulation of questionnaires. In this case the researcher was compelled to draft and redraft the questionnaire as there appeared to be no previously validated available questionnaire to elicit the MHS user' views about CCP. The weakness of this instrument is addressed later.

3.5 Forms of Data Collection.

The main methods of data collection in surveys are questionnaires, structured or semi-structured interviews and, occasionally structured observations (Parahoo, 1997). The questionnaire is a tool for collecting data and its function is measurement (Charles 1988; Oppenheim, 1992 and Newell, 1993). It is prepared in such a way that the format and the structure is exactly the same for every respondent. The term questionnaire appears to be employed in different forms. Some authors engage it exclusively for self-reporting and postal format while

others use it to include face-to-face structured interviews.

Administration of a questionnaire can be face to face, sent through the post, or completed by the respondent without any supervision and, in some cases by telephone. Using a telephone would have been expensive and some of the respondents may not have had a telephone. Above all, the use of the telephone may threaten their anonymity and in some cases raise suspicions of how the interviewer accessed the telephone number. Face to face interviews may be time consuming, in travelling to the respondents or to the units.

Questionnaires are relatively cheap financially to administer and less time consuming than interviews or participant observation. The two day units involved were situated at a distance apart, so using a postal questionnaire was cost effective. Furthermore, because the respondents attended for their respective therapies at different times, interviewing all the attendees by one interviewer would have proved difficult and time consuming. The questionnaire allowed for all the potential respondents to be included in the study without a major outlay of time and cost.

The completion of questionnaires was less time consuming for the respondents too, especially where the questions were mostly closed format and the respondents were required to choose from a list of responses. The data that were collected from all the respondents were in the same format. The open-ended type of questions may demand more intellectual effort, which may be off putting to the respondents or difficult to answer. Because of diversity in responses this format may present difficulties in analysis, but the responses can be employed to support some assertions made.

The strength of open-ended questions lies in their versatility to encourage greater respondent participation in expressing their views. Close attention was paid to ensuring that questions were clear when using open-ended questions. Clarity is paramount, as individual respondents may interpret the questions differently from others. A weakness of the open-ended format is that what is written may not be

clear and the necessary deciphering may prove time consuming (Fielding 1993). The design of the questionnaire is dependent on the research question and whether it is appropriate to provide the essential data to address the aims of the study. Questionnaires are usually standardised and structured, they appear to be widely used in nursing research.

The self-reporting questionnaire strategy was adopted to enable the respondents to complete the questionnaires privately, in their own time and pace and so not feel pressurised to provide a response (Newell, 1993). This is enhanced by the absence of the interviewer because the presence of an interviewer can be intellectually and psychologically challenging to the respondent. The impersonal nature of the questionnaire reduces the chance of the respondent being influenced, compared to interviews. Hence there is less interviewer or observer effect (Fielding, 1993).

The respondents may find comfort in completion of the questionnaire anonymously. The questionnaires offer greater assurance of anonymity and a sense of being in control in the knowledge that whatever is written is accessible only to the author. This can motivate the respondents to complete it. As Parahoo points out.

“The questionnaire is one of the methods of data collection that can potentially keep respondents anonymous” (Parahoo (1997: 276)

Because the researcher is physically not present, the questionnaires need to be devised in a clear, unambiguous manner and must be attractive to respondents. The opportunity is not usually available to provide clarification consequently errors are difficult to rectify once the questionnaire has been despatched (Bell, 1987). Providing precise instructions should avoid the situation and hence the questionnaire had to be clear. Piloting was performed and this removed any potential problems.

The set of questions should be relevant to the respondents in order to increase

motivation to fill in the questionnaire (Sarantakos, 1994). Motivation can be reduced when the questionnaire is too long and it risks being thrown away uncompleted (Newell, 1993). The literature does not provide guidance in relation to what is considered the right length although Fielding (1993) suggests about 6 pages or taking no more than 30 minutes to complete.

Weakness of questionnaire.

Limitations of questionnaires need to be considered. Unfortunately in completing questionnaires respondents may provide incomplete responses or miss out any item if they feel it is ambiguous or if they feel negative about it. They may recall incorrectly or may not even adhere to the instructions. The respondents may not understand what is asked of them or have difficulty in reading or writing. They may lie. The researcher had to take account of these factors when devising a questionnaire because incomplete or missing data can affect the findings of the study.

The response rate must be considered, as one of less than 100% may introduce unqualifiable bias. Every effort was adopted to avoid a response rate so low as to create a bias. It is fundamentally important to take necessary steps to ensure good response rate (Fielding, 1993). The following precautions were taken to enhance response rate: the purpose of the study was explained, the questionnaires were delivered and distributed by the author and there were no names or any information likely to be attributable to the respondents. Investigating how in-patient MHS users evaluated their service, Lovell (1995) distributed 66 questionnaires to the users but only 25 were returned. Lovell does not suggest ways of encouraging a good response rate.

In the current study there was no way of knowing who in the household filled in the questionnaire (Newell, 1993) for those who took the questionnaire away. It could be that the respondents had problems in reading or writing. Provided the respondent views are reflected in the response it could be argued that it does not matter who helps the respondent.

Rating Scales.

A questionnaire can be combined with a rating scale to measure opinions. The one commonly used is the Likert scale (Polit and Hungler, 1991 and Devaus 1991). The summative scale offers the respondent a series of items from which to respond. It uses a three, five, or seven point scale ranging from strongly agree, through to uncertain in the middle, to strongly disagree.

The respondents agreeing with the statement score five and those disagreeing score one. Reversal is crucial to indicate consistency and to reflect the level of an agreement with the statement; this demonstrates positive opinions regarding the attitude (Polit and Hungler, 1997). A Likert scale is easy to understand and provides precise information pertaining to the respondent level of agreement/disagreement (Devaus, 1991). However, the researcher has to be aware of potentially introducing response bias emanating from the inclusion of positively worded items versus negatively worded statements. Randomly mixing the items can minimise the response bias (see below for more detail).

Notably the weakness of the Likert scale is the interpretation of the number in the middle, which can present a lukewarm response or an individual adopting “a play safe approach”, or even lack of knowledge (Oppenheim, 1992). Identical scores may represent different interpretations of what is meant. However, it does provide information about a person’s level of agreement to a particular statement even though it may not necessarily reflect the actual behaviour of the respondent. Because of its simple way of construction, a Likert scale was included as part of the questionnaire in particular to measure the respondents’ views towards the social environment.

Thurstone scales

Another scale that was considered but found to be unsuitable is the Thurstone. Formulation of the order of items to approximate equal intervals is crucial in the construction of a Thurstone scale. The list of items is constructed with the aid of experts who are familiar with the construction of the scale (Sarantakos, 1994).

Involving the MHS users, in the formulation the scale, would pose problems. Simply because of the nature of their therapies it was assumed that they would find contribution to the development of the tool rather difficult. It also demands a certain level of concentration, which some users would have found difficult to sustain for the time required. The greatest disadvantage of this scale is its decreased reliability in comparison with Likert scale due to reliance on subjective opinions of the judges. The respondent either agrees or disagrees with given items and there is no middle response. Thus the Thurstone scale was rejected.

Group discussion

Group discussion was thought of as another method of collecting data. Group discussions have a special value in exploring a range of views about a particular issue (Marshall and Rossman 1989). They are useful in such situations as consensus information within an interaction process and give the researcher an opportunity to observe group dynamics.

This form of data collection was felt to be unsuitable for this current study because some MHS users may feel intimidated within a group set up and this might inhibit effective participation in discussion. It is suggested that with this approach two co-researchers are required to ensure one person concentrates on the management of the group and the other on the audiotape recording equipment (Fielding 1993). Being a sole researcher it would have been difficult to fulfil those conditions. Furthermore, not everyone who is invited to participate in a group discussion attends. This could introduce a bias to the results. However group discussion was considered in the pilot stage of this study in order to obtain feedback about the questionnaires.

3.6 Designing the Questionnaire.

Two sets of questionnaires were developed, one for the MHS users and one for the health professionals. There appeared to be no validated tool specifically looking at the CCP from MHS user' perspective. There is, however, a tool designed to measure some aspect of collaboration between nurse and physicians

(Weis and Davis 1985) but this was not used. The questionnaire size was designed sufficiently to address the objectives of the study (Sarantakos, 1994). It comprised 30 questions. The fact that no existing validated questionnaire was available is acknowledged as a weakness in the data collection

It focused around the three main areas: Definition, decision-making and social environment. McNeil (1990); Newell (1993) and Sarantakos (1994) point out four elements to be considered when constructing a questionnaire:

- Layout
- Content of the questions
- Format
- Relevance to respondents
- Layout

A questionnaire by its nature should be easy to read and follow. The chosen questionnaire contained three elements. First, there was a cover letter inviting respondents to participate and explaining the purpose of the study. Secondly, there was an introductory letter with the consent form (Appendix, 1), which the users had to complete stating their willingness or unwillingness to participate in the study. Thirdly there were instructions to be followed regarding the return of the questionnaire together with the document with important questions to address the study (Appendix, 2).

The layout was constructed with respondents in mind to ensure that respondents followed the instructions and understood what was asked of them. As there was no opportunity for respondents to ask for further clarification, any confusion/ambiguity would have discouraged the respondents from filling in the questionnaire.

Careful thought was given to the sequencing of the responses to discourage the respondents from making a psychological 'jump' from one thought to another something which would have caused them to lose concentration. Standardisation

and the structure of the questionnaire afforded consistency, and all the user respondents were asked the same questions. However, slight differences existed between the questions asked of the users and those of the health professionals (Appendices 2 and 4).

A qualitative open-ended question was placed at the end. This allowed for richer and fuller data on perspectives of CCP. It enabled free expression, if the respondents wished to make additional comments. (Polit and Hungler, 1997; Lovell, 1995).

- Content of the questions

Every effort was taken to ensure that respondents understood the wording of the questions. If words or phrases are complicated ambiguity may result. Professional terminology, for example, “collaborative care planning” was deliberately incorporated to ascertain whether MHS users were aware of it. Additionally, great thought was given to the use of language understandable to respondents. Most of the questions were developed from the literature. Consideration was given to ensure that the questions were relevant to the topic (Babbie, 1995). Hence, the questions were focused on areas surrounding the concept of CCP in three main areas including: meaning of CCP, decision-making and social environment.

The first section of the questionnaire encompassed questions related to demographic information in order to facilitate group level comparison. This was to ascertain whether the demographic variables (independent variables, questions 1-7) influenced the pattern of responses. Questions 8-10 focused on the understanding of the meaning of the term CCP. It was felt that because CCP was supposedly being practised, the MHS users would know about it. Questions 11-15 elicited views related to decision-making process.

In addition the Likert type scale consisted of 16 statements. The number of items is arbitrary but 10-20 would seem to be acceptable (Polit and Hungler, 1991).

These elicited the respondents' degree of agreement and disagreement about the social environment. The main purpose was to ascertain MHS users' views about the social environment in which the concept of working together takes place.

The intention was to construct a uni-dimensional scale that measured the concept of social environment. Firstly there was the construction of a pool of statements that measure the views associated with social environment. Secondly, Likert scales contained a mixture of both favourable and unfavourable statements. The rationale for mixing them was to prevent acquiescence with all statements (Devaus, 1991). This encouraged the respondents to think about their responses before selecting their position on the continuum. Five of the statements were positively and seven negatively worded (Henerson et al, 1987). A five point Likert type scale was used ranging from strongly agree (5) agree (4), uncertain (3), disagree (2) strongly disagree (1), and a space for any further comments.

Thirdly, the reversal of scoring was crucial to indicate consistency, reflecting an agreement with the statement indicating favourable views towards the social environment (Polit and Hungler, 1997). 'Strongly agree' with positively worded statement indicated a favourable stand towards the social environment.

- Format

The specific types of questions were determined by the kind of data required. For example, closed and open-ended questions were employed to facilitate respondents in providing the relevant information as calmly as possible. Use of vague words and questions, which sought views on more than one statement, were omitted as they may annoy or confuse the respondents. Similarly leading questions were avoided. Furthermore, the type of questions employed influenced how the analysis of the data was performed. For example the closed questions were easily analysed and allowed comparisons to be made between the responses as they are in the same format. However, the weakness is that it can introduce bias if an important response is accidentally omitted.

Hypothetical questions are discouraged (Newell, 1993). However, in this study, a few questions are of this nature to determine, for example, how the respondents would wish to be involved in the decision-making process. Incorporating these questions was helpful in establishing the best way for the respondent to be involved in the decision-making; the factual questions were placed at the beginning of the questionnaire to stimulate interest (Newell, 1993). It is best to begin with simple and easy questions which are non-threatening. Those that need considerable thought were placed in the middle the stage at which the respondent has become familiar with the questionnaire. It is believed that commencing the questionnaire with factual statements is off putting and should be better placed at the end (Oppenheim, 1992). It appears that there is no consensus as to what constitutes the best approach. Placing factual questions in the middle did not present any problems; this would have been identified by the pilot study.

- **Relevance to respondent**

The other aspect of questionnaire construction that was taken into consideration was that of valuing the respondents. It was crucial to consider the ability and willingness of the respondents to respond to questions and whether they were knowledgeable enough about the topic to be able to provide the necessary information (Moser and Kalton 1971). That was achieved at the commencement of the study.

3.7 The Sample Population

The sample refers to a portion of all those people who could be included in the survey (McNeil, 1990). The population under study was all the MHS users and health professionals in the mental health Day Care services and all of them were included in the study. Two day care units that were the same as far as the functional roles are concerned.

All the MHS users came from the community. However this was not a sample population that is representative of the whole population. The larger the sample

population and depending on the sampling method, the more representative of the population it is likely to be (McNeil, 1990). The focus is on how particular views or beliefs are distributed.

Inclusion criteria

The criteria for inclusion were that they had to be MHS users attending the day care facility and well enough to answer the questions. MHS users who were overtly behaviourally disturbed were to be excluded depending on the advice given by the nurse-in-charge. The choice of the day care facilities was mainly purposive because they claimed to be practising CCP.

3.8 Pilot Study.

A pilot study is a small-scale version of the main study that tests the research methodology before proceeding to the main study (Preston and Soeken, 1989). The purpose is to remove any potential problems, to assess the feasibility of the study and adequacy of the instrument by removing problems in the instrument as well as the methodology (Bell 1987). It also served as a way to gauge the MHS users' ability to understand the questions.

Ten questionnaires accompanied by addressed, stamped envelopes were sent to the study areas to be distributed to the day care MHS users. Subsequently only two completed questionnaires were returned by post after two weeks. The follow up in order to retrieve the rest of the questionnaire was beset by problems. Because the users had been given the questionnaire by different members of the staff there was no proper co-ordination. Some of the users had left the questionnaire behind in the care setting. This was a fruitless exercise.

Following a discussion with the academic supervisor, it was felt that repeating the pilot study with same day care population might result in research fatigue and the users would lose interest in the main study. Consequently, it was decided to administer the questionnaire to ten in-patients attending the day care facility. Two

sets of questionnaires, ten questionnaires for the MHS users and three to the staff, all in individual envelopes, were delivered by hand to the day care settings for distribution. All the questionnaires were handed to the nurse-in-charge to distribute to the MHS users who attended the day care from the adjacent acute care settings and, also the health professionals.

The MHS users were willing to participate and also the nurse-in-charge had to judge them to be well enough to participate. This group was dissimilar to the users population for the study. Of great importance was that the in-patients involved in the pilot study were exposed to the concept of CCP. They also spent a day in the day care setting exposed to the same practice as the day care users from the community. The point of studying the in-patients was to test how the mechanism of distributing and returning the questionnaires and the understandability of questions would fare with MHS users.

Each questionnaire had an accompanying explanatory letter, with a pre addressed envelope and consent form. The respondents were expected to complete the questionnaire on the spot and place the questionnaire in a large envelope that the researcher later collected. The respondents, who did not wish to participate, placed the unfilled questionnaire and consent form in an envelope indicating their unwillingness to participate.

The questionnaires were expected to be completed on the spot and be ready for collection within two weeks (Polit and Hungler (1997)). That time elapsed without response. The researcher collected five questionnaires three days after the deadline. Apparently some of the MHS users preferred to complete the questionnaire away from the day care setting. The rationale for this behaviour was not clear. It also transpired that not all ten questionnaires had been distributed to the users. The reason for non-distribution was unclear. It is possible that this was due to the busy nature of the centre. Five of the questionnaires had been completed on the spot and returned. On reflection it would have been better for the researcher to distribute the questionnaires personally and make a date to

return and collect them.

The researcher took an opportunity to hold a group discussion (referred to earlier in the forms of data collection) with the five users who had completed their questionnaires. The group discussion was essentially to ascertain their views about the appearance; layout and clarity of the instructions and general understandability of the questions (Polit and Hungler, 1997). The group discussion took place in the lounge and lasted fifteen minutes. The following comments were raised:

- The terminology was unfamiliar but they suggested employing the term *collaboration in care planning* instead of collaborative care planning.
- Open-ended questions presented a problem, in that the group felt some of the users were having difficulty in expressing their views in writing.
- The questionnaire was found to be too long. It consisted of 30 questions.
- The appearance, layout and instructions did not present any problems.
- No difficulties were experienced with the statements listed on the Likert type scale format.
- Two out of 5 respondents answered the open-ended question.

These comments assisted in the formulation of the final version of the questionnaire.

Selection of items on the Likert type scale:

The statements listed on the Likert scale were analysed through item analysis. This technique was employed to eliminate those items that were unsuitable (Moser and Kalton, 1971). Those statements that did not measure the concept of social environment were eliminated. Of the 16 statements only nine were found to measure the concept of social environment.

Cross checking of the responses was done in order to determine whether the responses to a particular item reflected the pattern of responses on the other items. Each item score was correlated with the respondent total score minus the item score (Devaus 1991). Co-efficient correlation was performed. This indicated resulted in nine items considered suitable in measuring the concept of social

environment. However, it was decided that because the remit of the study was not exclusively to construct a scale, all except those statements that had a weak negative correlation were retained. A total of twelve statements were retained. The staff questionnaire was then pilot tested on three health care professionals. The results revealed that the distribution and return would take two weeks. No changes to their questionnaires were necessary.

3.9 Final Questionnaire Subsequent to Results of the pilot study

MHS user respondents

Few amendments were instituted incorporating issues raised in the group discussion. The questionnaire finally consisted of 27 items inclusive of the Likert type scale, 1-7 (see Appendix 2) with a focus on the demographic information that enabled a comparison between variables to be made. The independent variables such as age, occupational status and length of attendance were included to see if they had any impact on the dependent variables. (Users' responses) Closed questions were included as were qualitative statements requesting additional comments, should the respondents wish to elaborate on any aspect of the questionnaire. Following the suggestions from the pilot study the term CCP was employed interchangeably with collaboration in care planning.

Staff Questionnaire

There were no amendments following piloting, so the final draft questionnaire comprised 25 items inclusive of 15 statements listed on the Likert type scale (Appendix 4). Questions 1-4 included personal data and questions 5-8 measured the staff understanding of the concept of CCP. Question nine is a qualitative statement giving respondents opportunity to express their views about patients' involvement in the decision-making process.

3.10 Distribution and return of Questionnaires.

After consultation with the service managers and taking into account the findings

of the pilot study, the author delivered the questionnaires (total n=87, n=70 users and n=17 staff) to the care settings. Informed consent was secured through the explanatory letter and consent form (appendix 1). Reassurance was given that no repercussions would follow any refusal to participate. In addition, the collection of data without involvement of any of the familiar staff was another strategy adopted to ensure confidentiality and anonymity.

The collection of data through questionnaires took place during the months of February and March 1996. Initially the collection of data was planned to take place over a two week period, but due to bad weather, it was extended to a month. (In bad weather the attendance of the MHS users tended to be erratic). All but four respondents took the questionnaires away because they felt they could not concentrate at the centre. The four questionnaires were returned and placed in the designated collecting envelope.

Seventy questionnaires were distributed to the MHS users during meal times when they were not engaged in their specific therapies. Each day as the MHS user attended, they received a pack that contained a questionnaire together with consent form and pre-addressed envelope. Pens were available for filling the questionnaire. Pre-addressed envelopes were issued as another mechanism of maximising the response rate. It was assumed that this would reassure MHS users that their information or participation would remain confidential with the researcher. When the questionnaire was completed, often on the same day, the users deposited it in a large envelope placed for easy access.

None of the staff were involved in collecting the questionnaires. With that in mind it was hoped that the users expressed their views without fear of the information being available to the health professionals. Furthermore, no names or any identifying material was asked for. Although the staff knew that the user-respondents were participating in the study, they were unaware of the level of participation or response.

The Staff Questionnaire

Seventeen questionnaires were handed to the nurse manager to distribute to the health care professionals. Once completed the questionnaires were sealed in an envelope without being interfered with in any way. A large envelope was placed in the managers' office for returned questionnaires, which were collected within two weeks. Staff, according to the findings of the pilot study, tended not to complete the questionnaire immediately. This was due to heavy work commitment and inertia.

3.11 Validity and Reliability

Face Validity

The validity of the questionnaire is the extent to which it addresses the research question and objectives set by the researcher and the responses of the respondents actually answering what is asked (Parahoo 1997). Because there was no validated questionnaire available to measure the views of the MHS users, the researcher developed a specific tool for this study, underpinned by the conceptual framework of CCP. This is acknowledged as a weakness in the study as the questionnaire was not validated. There is however a collaborative practice scale that has been found to be valid and reliable in measuring collaboration between physician and nurses within a medical setting, (Weis and Davis 1985). Another validated tool exist which was devised to assess the level of collaboration between physicians and nurses in deciding to transfer a patient from intensive care setting to a general medical ward (Baggs 1994). Both of these tools were thought to be unsuitable because the population and the context in which the studies were carried out were not in line with the aims and objectives of the current study.

At face value the questionnaire appeared to be measuring the concept of CCP. Furthermore, piloting the instrument to ensure the MHS users were able to follow the instructions, and making the necessary amendments increased the face validity. However, the homemade nature of the unvalidated instrument is

acknowledged as a weakness in the research design

Content Validity

The questionnaire included the elements of CCP as reflected in the literature. Although the expert knowledge of people conversant with CCP was not sought, the questionnaire was nonetheless scrutinised for adequacy and relevance of the questions. The comments from the academic supervisors ensured that questionnaire addressed the objectives of the study, and two colleagues' suggestions were incorporated in the construction and the piloting of the questionnaire.

Reliability

Reliability refers to the ability of an instrument to produce consistent results. Sarantakos (1994) says that it is equivalent to consistency. The context in which the questionnaire was administered can have a bearing on the reliability. The MHS users might have felt psychologically pressurised to fill in the questionnaires because of their "captive" status and by the presence of the researcher distributing and collecting the questionnaires.

The limitation is that the instrument was not subjected to a rigorous test devised to assess the consistency with which questionnaires collect data (Parahoo, 1997). The test –retest reliability test could have been used to find out the consistency with which questionnaire gather data but because of the pattern of day care attendance it was felt that this might reduce the response rate. This test involves administering the questionnaire on two separate occasions to the same sample population and comparing the responses to determine any discrepancy, which would constitute unreliability or an existence of an intermediating variable.

Chapter Four

- Data Analysis
- Findings

CHAPTER 4

FINDINGS

4. Introduction:

This chapter presents the findings of the questionnaire completed by respondents (MHS users and members of care staff). The chapter begins by describing how the data were managed in preparation for presentation. This is followed by an analysis of the number of questionnaires returned, characteristics of the sample and the main themes of the questionnaire, which are:

- The understanding of the term “Collaboration in care planning” as perceived by the MHS users and members of staff.
- The decision making process
- The social environment

The social environment is dealt with separately, analyzing each response in relation to the level of agreement/ disagreement among the MHS users.

Staff responses are used to support or validate the awareness of the term “Collaboration in care planning” among MHS users, but where substantial variation or similarity occurs between responses of users and staff, comparisons are drawn.

4.1 Data Management and Findings

First, the questionnaires were scanned for completion as the researcher collected the responses. The scanning process was employed with each incoming questionnaire.

Initially the researcher processed the data manually and then by computer for further analysis. Assignment of identification numbers to each questionnaire was necessary for ease of rechecking in case of errors in transferring the data onto the summary sheets or for further analysis.

Secondly, the questionnaire responses were transferred to the summary sheet. A numerical code was allocated to each response. The conventional method of coding

suggested by Fielding (1994) was adopted. The code numbers utilized were one to three or more depending on the category of response, missing data was assigned a nine and the “ Don’t Know” response an eight The code numbers were merely labeling devices to facilitate computation; Bell (1987: 104) confirms this by stating that ‘ these numbers constitute a nominal scale for measurement’. Next, the summary sheet composed of variables showing the appropriate code numbers was compiled. Thirdly, there was counting and summation of the answers for each variable from this a pattern of distribution of responses emerged. In spite of the small sample it was decided to use the computer to afford diagrammatic presentation and, as previously stated, to facilitate analysis. Fielding suggests that

‘ If you have used more than 20 questionnaires in which more than five questions have been asked, it makes sense to use a computer, (Fielding 1993:233).

The questionnaires were analyzed using a Packard Bell, personal computer utilizing a Microsoft Excel 5.2 version. The data were mostly nominal and ordinal in nature, and hence frequency and cross tabulation were computed. Fourthly, there was management of responses to 12 items listed on the Likert type scale (Oppenheim, 1992; Polit and Hungler 1995).

4.2. Sample Response Rate

Seventy-two questionnaires were completed out of a possible 87, giving a response rate of 83 per cent and a 17 per cent non-response rate. The staff completed and returned all their questionnaires (100%) Table 1 shows the distribution:

Table 1: sample response rate

	MHS users	Staff	Total
Sample population	80% (70)	20% (17)	100% (87)
Non-response rate	17% (15)	0	17% (15)
Response rate	63% (55)	20% (17)	83% (72)

In order to determine whether the non-response rate created a response bias, a wave analysis was performed as the questionnaires were culled from the respondents. As

Creswell (1994) states, in order to:

.”Determine whether responses change substantially from week to week. This procedure assumes that those who return questionnaires in the final week of the response period are almost always non-respondents. A case for absence of response bias can therefore be made.”

Creswell 1994: 125

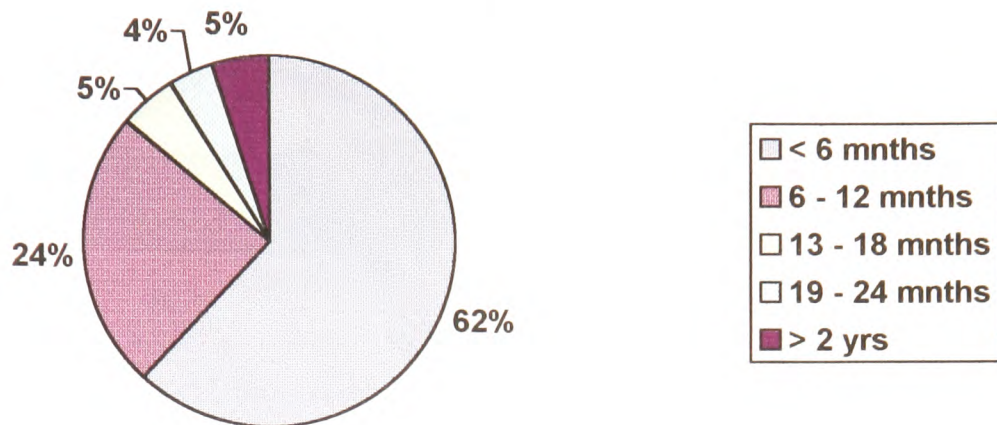
The questions were examined for week four to look for major differences from those of other weeks. This entailed monitoring the answers to questions: 9,10, 11 and 15 for the first three weeks and seeing if there was a noticeable change in responses to the set of questions that came in late at the end of the fourth week. The last questionnaires collected showed no substantial difference from the ones that had been completed and collected during the first and following consecutive two weeks. Which indicated that the absence of the fifteen responses did not greatly affect the overall results of the survey.

4.3 Sample Characteristics

The independent variables comprised the demographic details of the sample population's age, occupational status, gender and the length of attendance, in the Day unit.

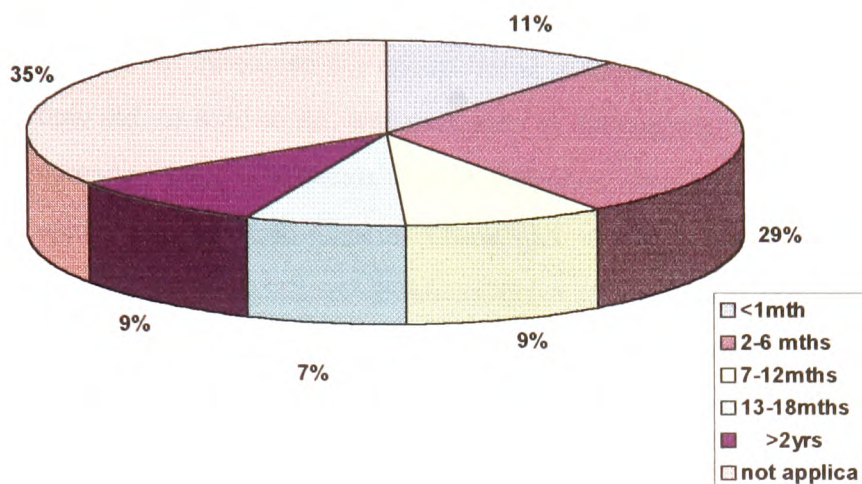
Most of the respondents had been attending the Day hospital for less than 13 months. The average duration of attendance was 7.13 months. The distribution of responses fell into all categories as shown in the diagram below

Figure 2: Length of attendance in percentages



However, 65 per cent (36 out of 55) of the service users had been in-patients between over one month and two years previously, and 35 per cent (19 out of 55) had not been in-patients. Of the latter, 58 per cent of them had been attending the day hospital for a period of less than six months and the remainder less than 19 months, therefore, giving them sufficient time to have been exposed to the practice of collaboration in care planning. Figure 3 illustrates the time, which had elapsed between in-patient admission and attendance at the day unit.

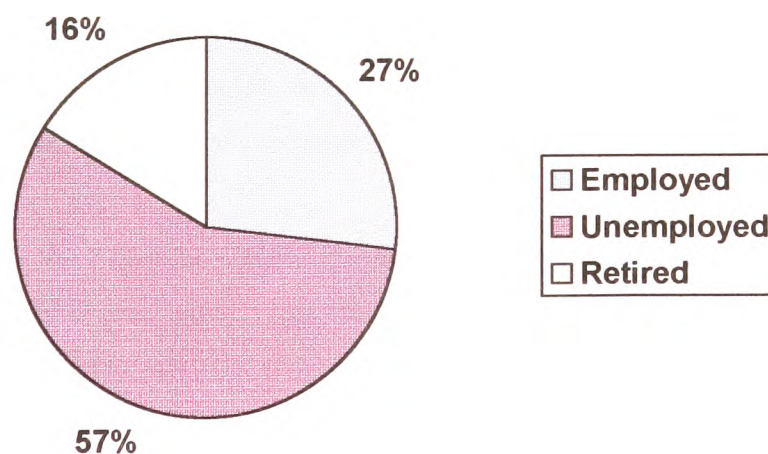
Figure 3: Time elapsed between discharge from hospital and before before day unit attendance



Employment status

At the time of culling the data 40 out of 55 were not in paid employment. (Figure 4 below) Only 27 per cent (15 users) were employed.

Figure 4: Percentage of service users in employment



Occupational status variable

In order to determine the occupational status of the respondents, the type of work they did, or used to do, was analyzed. A diversity of occupations emerged that was spread widely. This necessitated categorizing them into eight different social classes using the Registrar General Classification of occupations (Senior and Viveash 1998). The occupational groups of these categories are selected in such a way as to bring together, as far as possible, people with similar occupational skills.

This study followed the same process in determining the social class. The Registrar General's Classification was chosen because it is the mostly widely used tool for measuring social class (Morgan et al 1991).

However, it does have its weakness. It is not internally homogeneous, that is, in Class II a manager can be of a large firm in contrast to a manager of a two man firm: but both fall in the same group. This demonstrates that classification measures primarily status rather economical power or living standards. Furthermore, men are allocated to a particular social class on the basis of their occupation, whereas married women are allocated a particular social class in accordance with their husband's classification. Information related to marital status was not sought in this questionnaire. Women who did not work out side the home were not classified. Consequently categorization was based on the respondents' current or previous employment regardless of gender or marital status.

Although the Registrar General's Classification was used because the diversity of occupations it was decided that only two categories would be employed. Social Class I to Social Class IIIN would be considered to be non-manual and Social Class IIIM to V assigned manual category. Manual category consisted of 31 MHS users and there were 18 in the non-manual category. Six MHS users did not indicate their occupational status.

Two academic colleagues helped to analyze occupations into the two categories of non-manual and manual, (see Table 2).

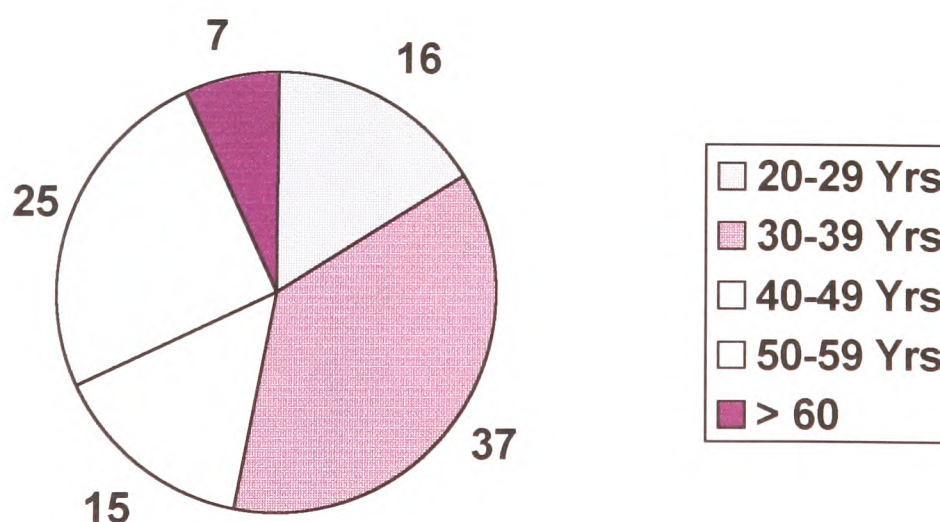
Table 2: Occupational categorization

Social Class	Occupation	Categorization	No.	Examples
I	Professional	Non manual }	18	Lecturer
II	Intermediate			Nurse
III N	Skilled non-manual			draughtsman
III M	skilled manual	manual }	31	bus driver
IV	semi-skilled			postman
V	unskilled manual			labourer

Age Distribution

The age of the service users fell into a number of categories. However, the largest proportion belonged to the 30-39 year group. The mean age of the respondents was 42.09 years.

Figure 5: Age distribution of the MHS users, n=55.



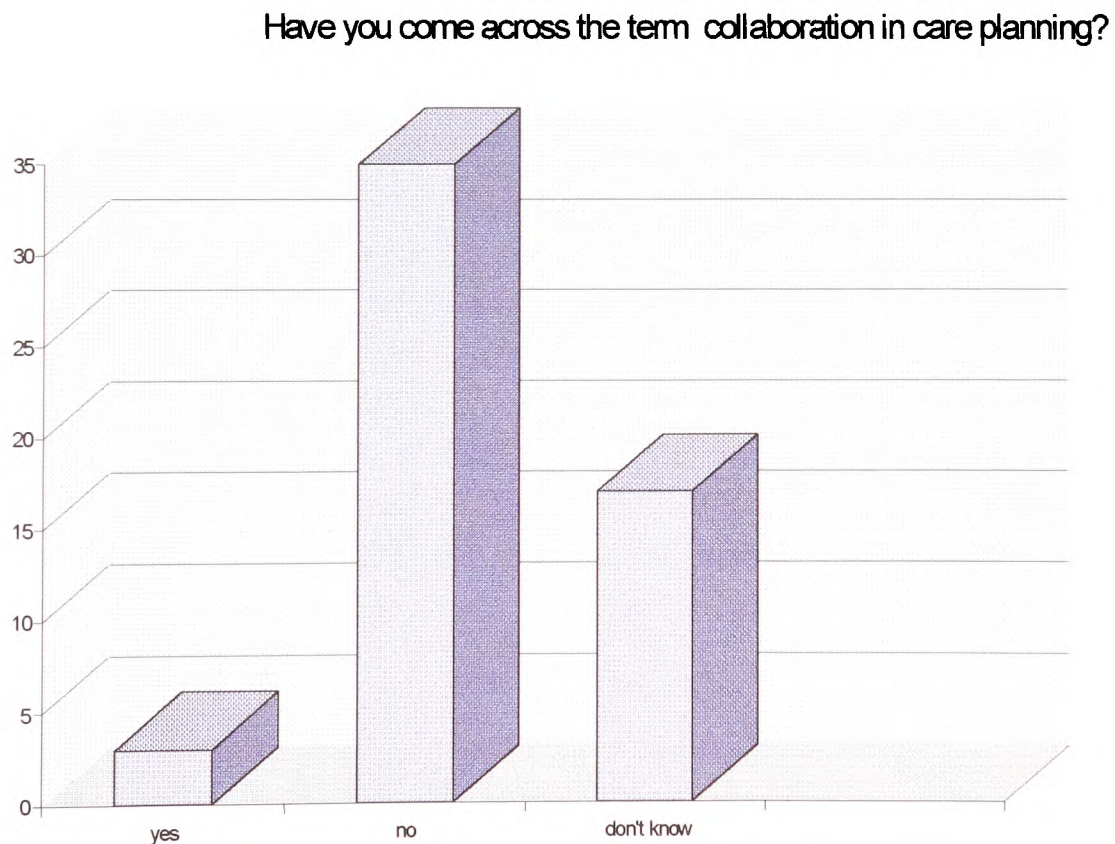
Gender variable

68 per cent (n=37) of the respondents were females compared to 32 per cent males (18 out of 55 five), which reflect the high proportion of females attending the Mental Health care service (MIND 1992). The ratio of females to males is 2.05: 1.00 which is representative in the general population of people suffering from mental health problems.

4.4. The Meaning of the Term Collaborative Care Planning.

Question 8 ‘Have you ever come across the term Collaboration in care planning used in hospital or the Day hospital? Only six percent (three out of 53) service users had heard of the term and these were professionals belonging to the non-manual category.

Figure 6: Bar chart illustrating the number of MHS users who had come across the term Collaboration in care planning, n=55.



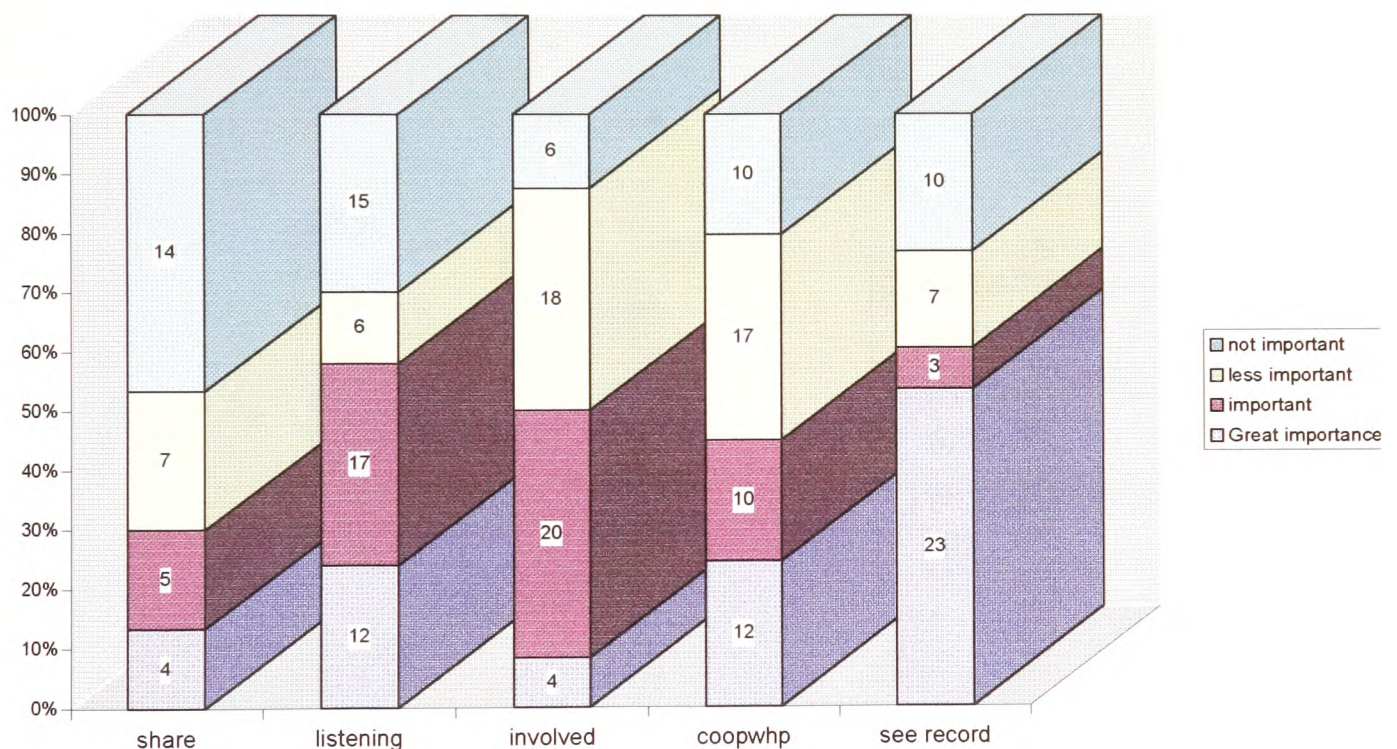
A high proportion of the MHS users agreed with the statement “ **Health care professionals should work together with patients in planning care**’,

**Table 3: Level of agreement /disagreement to health care professionals
should work together with users**

	N = 55	%
Agree	40	73
Disagree	4	8
Don't Know	11	19
Total	55	100

Asked to rank their responses in order of importance as to what they considered important in CCP. A large number (23 users) of MHS users considered seeing what was written about their care to be of great importance, followed by the importance of being given the choice to be or not be involved in their care. (Figure 7 shows the general distribution of the responses)

Figure7: Aspects in planning care ranked in order of the importance.



Meanings to the codes n Figure 7:

Share- sharing information with the health professionals

Listening- health professionals listening to my views about care

Involved-Involved or not involved in my care

Coopwhp- cooperating with the health professionals

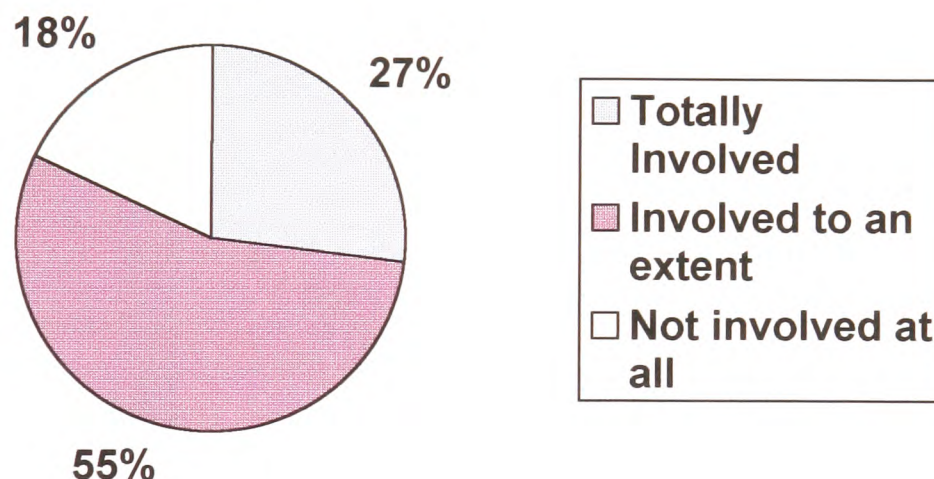
See record- see what is recorded about my care

4.5 Decision-making in planning cares

Question 11 attempted to elicit the degree of concern of service users being involved in deciding their care. A high percentage of the respondents expressed a wish to be involved in the decision making of their care whilst 15 per cent (eight out of fifty five) did not wish to be.

The response to question 12 to “**what extent would you like to be involved in decision making of your care**”, showed that 18 per cent were reluctant to be involved, (see figure 8) exceeding the number of respondents who expressed no desire to be part of the decision making process.

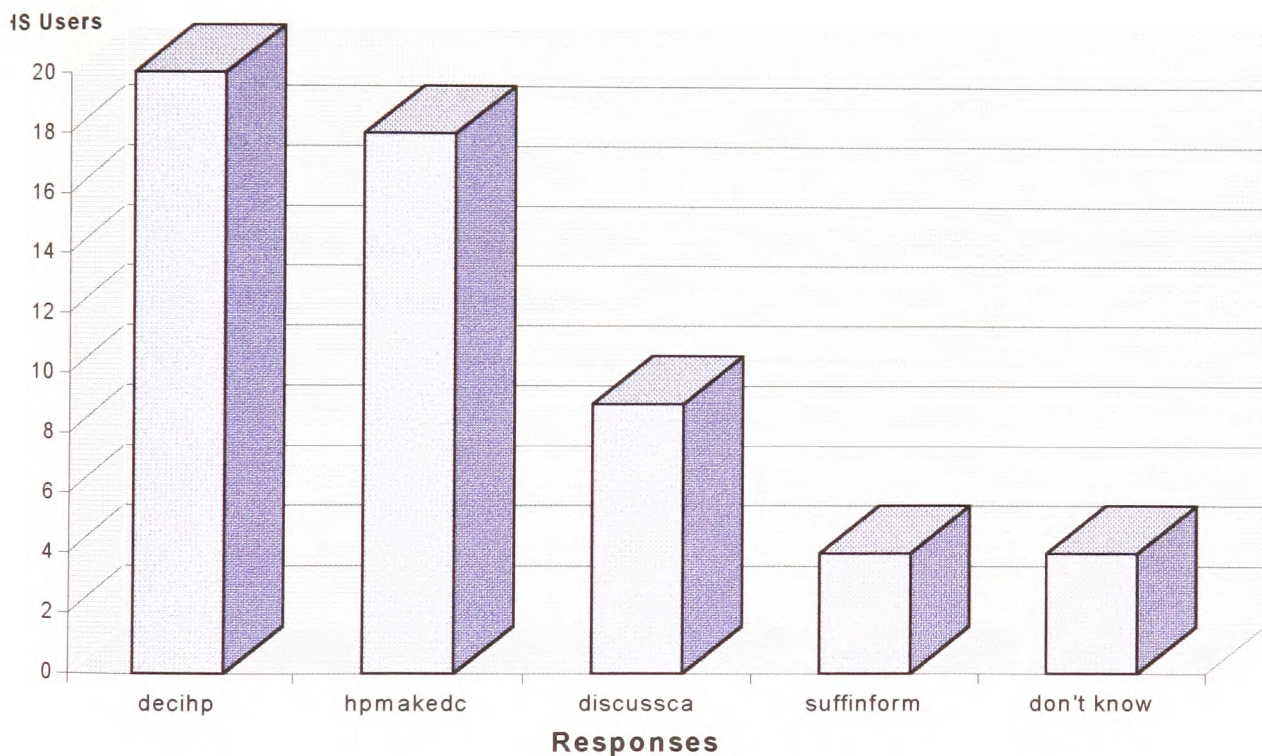
Figure 8: the extent of involvement in the decision making of care n=55.



Question 13 sought the views as to “**How would you like to see decision -making taking place?**” The responses were scattered across all the categories. Again a high proportion (36 per cent) said they would like to decide together with the health care professionals upon the care they required. The desire to decide with the professionals is congruent with the previous response that showed that some users wanted to be involved totally in decision-making and others wished to be involved to a certain degree.

Cross tabulation between age variables and question 13, decision making showed, that the age groups between 20-29 and 30-39 years wished to decide together with health professionals the care they require. In contrast the age groups 50-59 and 60 years and over preferred health professionals to make the decisions but to consider their views.

Figure 9: Illustration of how the service users would wish the decision making process to take place



The meanings to the codes in figure 9.

Decipher - Deciding together with health professionals the care I require.

Hpmakedc- Health professionals making decisions but considering my views.

Discussca - Discussing my care with health professionals and me personally making the final decision.

Suffinform - To be given sufficient knowledge about my health needs to enable me to decide.

In question 14 the users had to indicate whether they had any control over their care, 62 per cent thought they had, whereas 38 per cent felt they did not.

The last question showed that the respondents felt that the way the day hospital was run helped them to work together with the staff. The distribution of responses was across all categories with the majority (60%) agreeing that the Day hospital enabled them to work together with health professionals (see the Table 4 below). However, 18% of the users gave a “do not know response”

Table 4: Does the way the day hospital is organized help you to work together with health care professionals?

<i>response</i>	<i>N=55</i>	<i>%</i>
yes	33	60
no	12	22
don't know	10	18
total	55	100

4.6 Social environment

Question 16, relating to social environment employed the Likert type scale. The results were presented under the following categories:

- Overall response to the statements using the Likert type scale
- Individual accumulative total scores to indicate the MSU users' views about the social environment
- The level of agreement among the service users and the staff as to social environment.
- Qualitative responses made by the service users

Overall responses to the statements listed on the Likert Scale

Table 5 shows the proportion of MHS users who responded to each statement. Generally the responses to the statements are negative towards the environment. Seventy-three per cent (40 out of 55) users agreed with the statement “ Health professionals ignore my views about care”

Forty-two per cent of the statements were positively worded; i.e. 3, 5,7 & 9 as indicated in table 6(*). Thirty four per cent (34%) of service users disagreed with them, and 15 per cent were undecided. Yet 82 per cent (45 out of 55) agreed with the negative statements (see Table: 5)

Table: 5 show the numbers of the service users who agreed or disagreed with the twelve items listed using on the Likert scale)

Statement		Agree	Uncertain	Disagree
1*	The staff encourage me to be independent	5	3	47
2	Health professionals ignore my views about care	40	7	8
3*	I am treated as an equal partner with health professionals.	8	17	30
4	I feel I 'm not in control of the care I am receiving.	39	3	13
5*	I should be allowed to see my care plan	41	10	4
6	I am not encouraged to question my care.	32	9	14
7*	Patients are consulted at each stage of their care.	32	11	12
8	I am not well enough to be involved in planning my care	40	5	10
9*	Patients should be given more respect by health professionals	32	16	7
10	Nurses/doctors know what is best for me	36	12	7
11	As a patient I do as I am told without questioning	37	6	12
12	Professionals without my involvement should take all decisions about my care.	20	10	25

Note (*) denote the positively worded statements

Individual accumulative total scores

To ascertain the individual scores the following procedure was adopted. The responses to the twelve items were scored in such a way that endorsement of positively worded statements was assigned a high score. Similarly non-endorsement of negative statements was assigned a high score, as illustrated below.

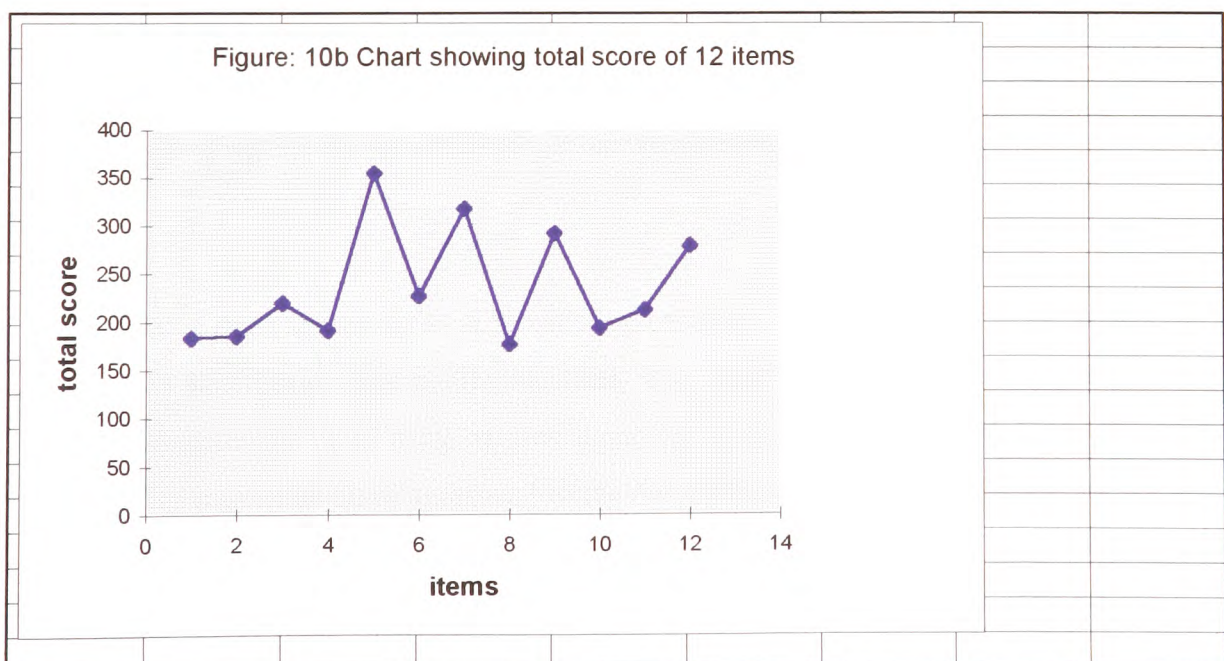
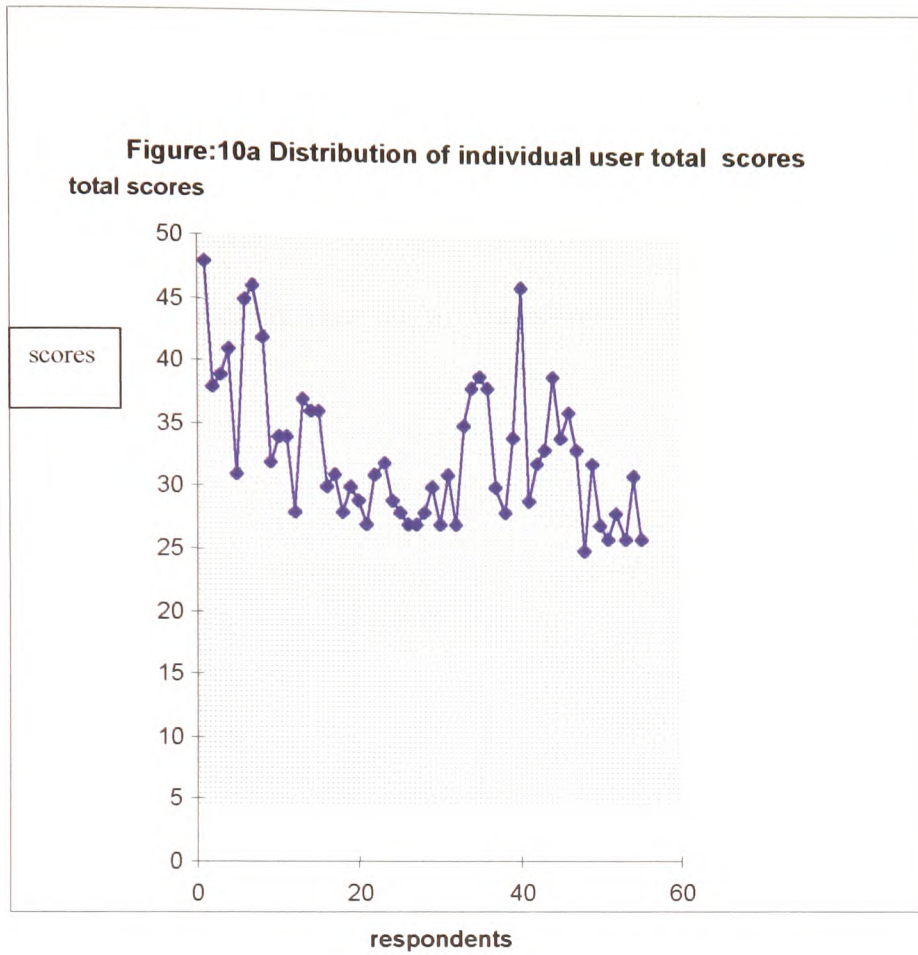
Postively worded statements:		Negatively worded statements:	
Strongly agree =	5	Strongly agree =	1
Agree =	4	Agree =	2
Uncertain =	3	Uncertain =	3
Disagree =	2	Disagree =	4
Strongly disagree =	1	Strongly disagree =	5

Each respondent's score was computed by totaling the scores corresponding to their responses (see appendix 6). In essence the twelve items permitted a possible minimum score of twelve to a maximum possible score of sixty for each service user (see Figure 10a). Each item was subjected to this scoring process and summated to provide a grand total. A reverse scoring of negative statements was also necessary whereby a high score would consistently reflect a positive stance despite the negative statement (Polit and Hungler, 1995; DeVaus, 1991)

Therefore, for 55 service users the total pool of items permitted a possible score of 660 to a maximum possible score of 3,300. For the purpose of the study scores ranging from 1650 to 3,300 would be indicative of very positive views towards the social environment. From 660-1650 will constitute a negative view towards the social environment. A total score of 1805 (54.6%) was attained, indicative of a tendency towards a positive opinion of the social environment (Figure 10b).

The observation of distribution of total scores showed a unimodal distribution of 28 and a range of scores between 25-48 and the standard deviation of .53.

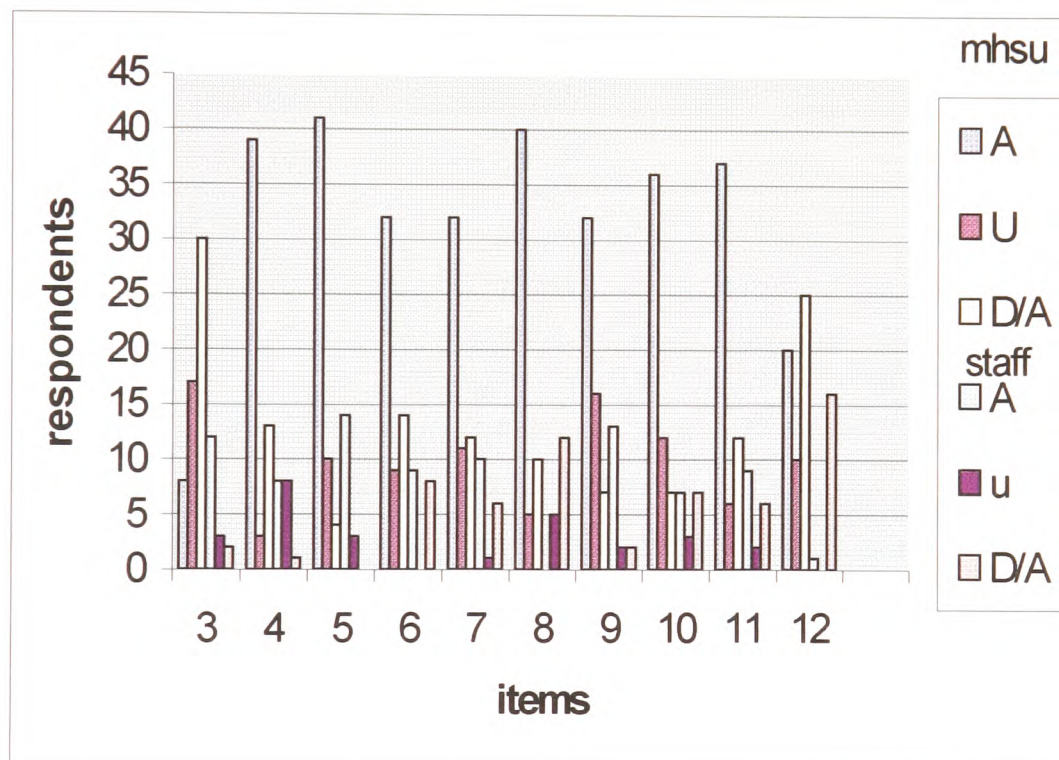
The overall views expressed collectively were slightly positive to the social environment (54.6%).



The level of agreement among the users and health professionals.

Ten of the statements were similar. Users' and health professionals' responses were compared and contrasted.

Figure 11: Bar chart showing a comparison of responses to common items on the Likert scale



The above chart shows different levels of agreement/ and disagreement to the items on the Likert Scale. The finding illustrate, first, how the service users had a high level of agreement on all items bar item number 1, as depicted in the diagram (Figure 11). The highest levels of agreement to the items among users being 75% compared to 82% of the health professionals. Secondly, 73% of user respondents agreed with the statement, 'Patients are not well enough to be involved in planning care' while 71% of health professionals disagreed.

Thirdly, another observation to note is the responses of the health professionals were equally divided between 41% and 41% agreeing and disagreeing with the statement 8, “nurses/doctors know what is best for patients” respectively.

Fifty -five per cent (55%) of users felt that they are not treated as equal partners with health professionals. However 71% of the latter disagreed.

Qualitative questions yielded a diversity of comments, which were difficult to code, and categories, but which could be used to support several arguments. However, some of the comments made were not directly related to the topic under investigation (see Figure 8a).

Figure 8a List of qualitative responses

Below is a list of all the comments made to the open-ended question

- "Patients should be involved in decision making. Doctors should listen more to the patients, as they will then know what is really wrong. Nurses are excellent at listening.
- Since being involved with this day hospital I have nothing but admiration and gratitude for the staff attention and care I have received from all doctors and nurse who have treated me.
- I feel being hear (sic) made me feel much different to what I have been feeling because no one really talks to you much about anything and I don't really know if I would attend much longer. I feel depressed; there is really no one around when you need someone.
- Some nurses/doctors treat us with respect and treat us very fairly but some nursing assistants on the ward treat patients with complete disrespect. I also found it very intimidating when inpatient have to enter the room during the doctors round to find, may be 6 or more people.
- Need more choice in classes here, not everyone likes knitting, sewing or handicrafts.
- I feel that I have been treated very well and cannot find any room for improvement.
- Didn't like the way patients on section were treated .As a voluntary patient I am willing to help myself. Staff and patients should work together not fight each other. The patient may need outside help in order to make decisions
- A good trend to include patients. May understand why certain course of action is being followed but the final decision should be in the hands of the professionals. I think the decision-making between both parties should be considered.
- Patients should be involved in deciding. They are best informed of how they feel.
- Decision-making depends on the whether they are ready to take part. It becomes a self-fulfilling prophecy otherwise. Patients don't have perfect knowledge on health care so all options need to be explored.

Staff Responses

The following health professionals worked at the units during the collection of data. There were eight nurses, two medical officers, six occupational therapists and one psychologist.

Seven health professionals had been working in the day units for less than a year. Three had been in their current post for more than ten years. Most of the staff had worked in the day hospital as indicated in the table below.

Table: 6 Length of service of the staff (n =17)

	<1year	1-3 years	4-6 years	>10
Length of service in current post	4	8	2	3
Length of time working in unit	7	6	1	3

Table: 7. Below indicate the Meaning of Collaboration in care planning as expressed by the staff.

Multidisciplinary team and patients working together to plan care.	52%
Involvement of all the disciplines in the care and treatment of the patient	12%
Multidisciplinary team working together to coordinate care	6 %
Involving patients in planning care and access to the care plan	12 %
No idea	6 %
Nurses and patients working together	12 %

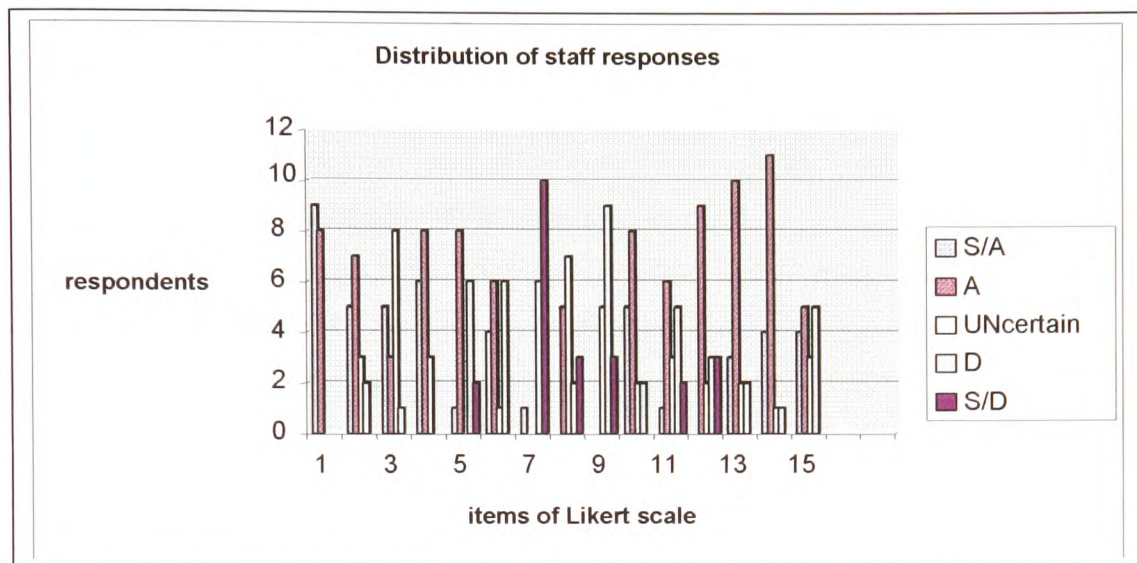
To question 7, “Are patients involved in Collaboration in care planning?” 82 percent of the staff said patients were involved but did not think patients were aware of the term Collaboration in Care Planning. However, 17 percent felt that patients did have some knowledge of the term, although another 12 per cent were not certain as to whether patients knew of the term or not.

To Question 9, staff commented positively about involving patients in the decision making process but some expressed the reservation that it was difficult to generalise as it depended on the stage and type of illness. One staff respondent commented, “ I agree but too much knowledge could be dangerous”, and another remarked that it would be a “positive step provided the whole process was well coordinated”

Eighty-two per cent of health professionals indicated that they were involved in collaborative care planning. Only 18% felt that they were not involved.

Asked to what extent, they thought patients would like to be involved in their care; the responses were no different from the users views. All the health professionals indicated that the users would wish to be involved to a certain extent. However a comparison of items relating to the social environment showed the distribution of responses using the Likert scale to be vastly different between the service users and members of staff. The staff responses were generally favorable towards the social environment as shown in Figure: 12.

Figure 12: Illustrating the level of agreement/disagreement to the items of the Likert scale.



4.7 Summary of the findings

The health professionals at the units involved had claimed that users were involved in CCP.

1. Eighty two percent of the staff indicated that the concept of working together was practised. However, the staff respondents indicated that the MHS users might not understand the terminology used.
2. A minority of user respondents (6%) had come across the term collaborative care planning. However, it is not clear whether their awareness of the concept of CCP was as a result of it being implemented in practice or because of their professional background.

3. The staff respondents provided different understanding of the meaning of CCP. None of them gave a definition similar to the American view of CCP that is incorporating critical pathways. There was clear indication of different understanding of what CCP entails. Fifty-two health professionals endorsed the concept of CCP as a physical gathering of different disciplines to plan patients' care, including the MHS users. There was no indication of care being documented in an integrated care plan or case notes.
4. The user respondents regarded seeing their records as the most important aspect of their care. Those who were uncertain about the service users working with health care professional nonetheless expressed also a desire to see their records. Of the 48% users who ranked "seeing the records" as of great importance 13% could not decide one way or the other whether working together with health care professionals was of any importance.
5. Thirty six per cent of the user respondents indicated that they would like to make decisions together with health care professionals but it was not clear exactly how this could be achieved.
6. Forty six per cent were not in favour of sharing information with health care professionals in meetings, such as a ward round. Sharing of information in a meeting was ranked to be of little importance. This finding is consistent with McIntyre et al (1989) and Sharma et al (1992) who found that MHS users disliked attending ward rounds, where the sharing of information is vital, in fact believed it to be unhelpful.
7. Eighty per cent of users wished to be involved in decision making in their care with a higher proportion expressing a desire to be involved to a certain extent. Fifteen per cent however, wished not to participate in the decision making in their care. Conversely, the staff felt that the degree of user involvement was dependent on the stage and type of their illness. All staff agreed that the users should be involved to some extent rather totally involved in deciding care.
8. Women were more than men keen to participate in decision-making.
9. Sixty -two per cent of MHS users thought they have as much control as they would want but the same question posed on the Likert scale indicated that 71% agreed with the statement "I am not in control of my care"

10. Examining any influence by age group, those aged 50-59 years preferred the health professionals to take all decisions but to consider their views whereas, the 20-29 and 30-39 age groups felt positively about making the decisions.
11. The accumulative scores of items on the Likert scale indicate weak positive view towards the social environment, with a score of 54.6%. Of the 42% statements worded positively, 34% users disagreed and 15% were undecided. Yet 82% of the users agreed with the negative statements indicating a negative view.
12. The staff response to items contained in the Likert scale was generally positive, showing a different perspective to that of the MHS users.

Chapter Five

- Discussion of Findings
- Limitation of the study

CHAPTER 5

DISCUSSION

5. Introduction

The objective of the study was to determine users' understanding of the meaning of CCP and elicit their views about their role in decision making regarding their care plans. Further more to ascertain whether social environment is conducive to CCP.

The discussion is structured along the main concepts of the study, which are: the term CCP, decision-making and social environment. In the discussion a comparison is made with some of the studies cited in the literature review.

5.1 Concept of CCP

The health professionals in the day care units believed that they were practising CCP. It was expected that many of the respondents would have come across the concept in practice and therefore, would have some knowledge about it. Only non-manual (n=3) MHS users had heard of the term CCP. Perhaps the non-manual MHS users were aware of the conceptual meaning used in other areas of their lives, not necessarily within a health care context.

The study did not seek to determine whether or not there was CCP in these care settings. The fact that 94 % of MHS user respondents did not know the term that does not necessarily mean the concept was not practised in reality. It might be that they had not been made familiar with the terminology. Common language would enhance the understanding of what is expected of each party involved in the care process. Users should be made aware of the system of organising care for them to be more responsible and feel part of the team.

Eighty two per cent of the health professionals felt that the MHS users were not aware of the concept despite its application in reality in the clinical practice. This

suggests a lack of communication between the MHS users and staff, if 94% of the users are unaware of the system of delivery of care. However, MHS users agree that health professionals and users should work together in discussing and decisions about care. It is desirable that the MHS users should be aware of practices in which they are involved.

It could be that the working together approach to care exists but MHS users do not recognise it as such. It appears that the health professionals perceive the existence of the concept of CCP, because of the traditional working practice that encompasses the nursing process as a mechanism in which users are supposed to be involved in the delivery of their care. It appears that the health professionals are not very good at communicating what they do to the users. Avis (1995) echoes similar thoughts that patients are often asked about the satisfaction levels related to the some aspect of care they have received, without being informed of the expected standard of care. Involving users in care planning is an accepted requirement of good practice (DoH, 1995). Equally it is good practice to orientate them to the model of delivering care, translated into terms that they comprehend.

This intention to promote users' involvement in deciding their care has been going on since 1980. In fact, Sullivan (1997) remarks that the nursing process has been practised for over 20 years, yet that has not aided the nurse/patient interaction in mental health nursing. From that comment it can be argued that the concept of working together is not the norm. Furthermore, even though nurses have embraced patient-centred care, the treatment they offer is still influenced by routine and task orientated care, which is not always consistent with the ethos of administering personalised care (Morrison, 1994).

The MHS users strongly agree that users and health professionals should work together in decision-making about care plans. Although they might be unfamiliar with the term CCP, they recognise the importance of collaborating with health professionals in any decision making process. It is apparent that new ways of thinking, with clear definitions of the role of the user, are required to meet the

increasing demand for collaborative interprofessional care and to make it a reality (Ross and Campbell, 1992).

A high proportion of users endorsed affirmative responses and eight percent did not agree with the statement “**health care professionals should work together with patients in planning care**”. This suggests that a minority of MHS users is not keen to collaborate. Some health professionals hold the view that doctors/nurses know best hence they encourage patients to do as they are told. Equally the patients (Henderson, 1997) expressed similar opinion that nurses ‘know best’. In that instance they do not perceive working with health professionals as an issue of importance as long as they get help to recover from illness.

Patients perceive that doctors and nurses have expert knowledge. This is a commonly held view demonstrated also in Tucker et al (1987) who found that patients often considered themselves as having a ‘competence gap’ and consequently expected to leave all the decision about care to health professionals and not question what they are told. Illman (1991) contends that patients may not know what they need. They may have no knowledge of how to participate in care (Pritchard, 1986). This idea disregards the personal knowledge that MHS users possess. Eight per cent of users although small, in number reflect the medical paradigm that underpins the MHS users view- points (Horsfall, 1997).

Surprisingly, 19% of respondents were uncertain about the answer to the statement “**health care professionals should work with patients in planning care**”. It could be assumed that such response is reflective of the uncertainty surrounding MHS users’ active participation in care; generally the role of the user has been that of passive recipient. With the government initiatives (NHS and Community care, 1990) promoting collaboration the users are not certain of what is expected of them. “Don’t know” may also indicate that despite confirmation that CCP was operational, in reality, it was invisible to the users. That may indicate lack of explanation or communication about the approach to care.

Role conflict may result if MHS user and nurse are unaware of each other's role. So it is important that the collaborative approach to care is made as explicit as possible in order to enhance an understanding of each other's role. Lack of understanding of what is expected of users in CCP can be misconstrued as passive receipt of care. Providing a single universal meaning that is understood by patients/users enhances quality interaction, and users might be more inclined to have a sense of ownership of the plans made about their care (Murray, 1997).

It is important for users to be aware of the practical dimension of CCP so that they may challenge and assess the quality of service they are receiving. To be able to provide a constructive feedback on the standard of service or care provided, the users require a level of some understanding of the processes and procedures explained, in comprehensible every day language (FitzPatrick, 1997; Baker, 1997).

Indeed, users' views should be sought on items that have a particular relevance to them, which would be achieved through full explication of what is expected of them within the health care context. In the literature the role of a user in the collaborative process is not clearly defined.

Although the health professionals provided a diverse meaning of CCP, the notion of working together is encapsulated in the definitions. The finding is not very different from other studies that have identified different perception among healthcare groups. For example Harris (1995) surveyed the professional groups on the statement that best describes to them what CCP entails. There was a variation of responses in the nurse and doctor groups, while the physiotherapist and occupational therapists concurred with the statement. Overall, there was an agreement among the groups that CCP involved "all professional groups, including the patient /relatives working together to plan care (Harris, 1995).

The increasing pressure to promote collaboration between professional groups and of patients in the delivery of care, calls for new patterns of working to be implemented. Unfortunately the findings did not reveal the possible ways except that the MHS users are keen to work together with health professionals.

The understanding of the concept of collaboration can help to develop the necessary skills. If health professionals are genuinely to include MHS users in a collaborative process, they will need to clarify their own changing role and acquire the necessary knowledge, attitude and skills. However, this proposal of acquisition of the essential skills is overlooked in the literature.

Further scrutiny of the concept of collaboration from a human relations perspective, revealed that it embraces a communicative process, attributes similar to those found in a counselling relationship that enhance an environment conducive to a collaborative approach to care planning.

Henneman et al (1995) looked at antecedents and consequences of collaboration. From the list of antecedents, the researcher's knowledge, experience, and the findings of this study suggest that MHS users appear to be unaware of the process of working with health professionals. Gibson (1991) asserts that when a concept lacks a clear definition there is tendency for it to be defined according to personal experience.

The ideology of collaboration calls for health professionals to accept that the MHS users may be responsible for their own health. Collaboration implies a degree of negotiation, choice and equality in relationship, so that even though the health professional disagrees with the MHS users' ideas of care, their views are still respected. Rarely are MHS users equal partners with professionals because of their status (Murray, 1997). They can be equal partners with health professionals if the opportunities are available and if they have the necessary information to function at a required level in order to collaborate in planning and delivery of their own care.

This would call for a change of culture and attitude in both users and health professionals. A change of behaviour too is required that recognises MHS users as equal members of the collaborative team rather than passive recipients of care. Decisions made with them rather than for them, would dispel the view that mental health service only pays lip service to user involvement in care planning

(Smith, 1988; Lindow, 1992). Of course, allowance should be given for those who choose not to be part of the collaborative team. The health professionals must acknowledge that not all MHS users want to participate actively in the delivery of their care, for various reasons, and their wishes must be respected.

Collaboration is challenging to health professionals for two reasons. First, shared information enables users to voice their opinions and challenge the practices that do not meet their needs. Secondly, the traditional low hierarchical status of the user, which typifies nurse/patient relationship, may not support a collaborative environment.

Age Variable:

The results showed that the younger age group is more ready to collaborate than older group. It could be due to socialisation in the elderly that requires respect for authority (Brooking 1980). The elderly may feel that the health professionals have expert knowledge. Kim et al (1993) carried out an international study which indicated how older respondents were not particularly keen to take an active role in collaboration with decision making about care, but quite content with the decisions taken by the health professionals. The overall difference in response to CCP is not great but nonetheless sufficient to suggest that age as a variable.

Gender:

The findings showed that 65% of users were female respondents. This is consistent with the findings that suggest that there are more female patients who utilise mental health service than men are (Mind, 1992). They are more likely to be involved actively in care. Studies confirm that women visit general practitioners often and seek help more than their male counterparts (Senior and Viveash, 1997). They are more conscious of their health status than their male counterparts.

If users are to be collaborative this demands a degree of knowledge, information and competence. Health professionals possess the knowledge derived from the

medical influence and from their training (Brownlea, 1987; Ashworth, 1992; Henderson, 1997). MHS users have their own personal knowledge and combining different knowledge sets would enhance collaboration.

It would appear from the findings that there is a gap in understanding of the concept of CCP between users and health professionals. If working together is to be a reality, shared information, valuing each other's knowledge and understanding of commonly used terms in practice would promote more active collaboration instead of the MHS user being dependent on the health professionals by having to constantly seek information.

Forty-two percent of those who expressed the view that health care professionals should work with the patients also wanted the opportunity to see their records. It could be argued that the fact that the MHS users' view the opportunity to see their records as the most important aspect of working together with health professionals, is congruent with the belief that people should take more responsibility over their health. This is influenced by the assumption that users have a right and responsibility to access information that concerns them (Audit Commission, 1993). Indeed, to be actively collaborative in the planning of care, they need to be knowledgeable about what is documented so that all care activities are transparent. Transparency is another concept embedded in the government white paper, "Involving the Public" (Welsh Office, 1998).

Given a choice to participate in decision making about care was not important to some of the users. In essence collaboration in care planning depends on a number of factors. First, severity and type of illness, which was highlighted by the some professionals, and secondly, the very relationship between health professionals and MHS users can influence the extent of collaboration. Some MHS users may not wish to have a choice and, to that end their wishes should be respected. Perhaps simply to participate physically in basic activities of daily living skills is adequate for some MHS users. Knowing that this option to, or not to, be involved in decision making about care is available and, can be exercised, if they so wish is valuable for a minority of MHS users.

This seems to suggest that collaboration as a process can fluctuate depending on the overall well being of the user at a particular time. In essence what it appears to imply is that when the user is well enough, he/she can contribute to decisions taken related to his/her care. When emotionally or physically unfit that choice not to partake in decision-making is still available and can be exercised. This has resonance in the care of the physically ill (Biley, 1992)

Patient collaboration is a dynamic process. Respondents, although recognising that collaboration is a new concept, nonetheless accept the positive aspect. For example one user respondent in a qualitative comment wrote:

“A good trend to include patients in decision of care, patients may understand why certain course of action is being followed”.

This implies that the concept of collaboration between user and health professional is seen as beneficial because it facilitates understanding of the course of actions taken to meet the users needs.

Analysing the overall views of the respondents with respect to the most important aspect of involvement in planning care a large majority (91%) wish the health professionals to listen to their concerns and at the same time they wish to co-operate with professional's views of care.

5.2 Decision Making.

Asked whether they would like to be involved in decision making about their care a large majority (82%) indicated that they would like to be involved in decision-making. Only 15% (n=8) did not wish to participate. This is congruent with most studies that have looked at patient participation. They have revealed that generally not all patients want to be involved in care. Henderson (1997) offers a conceptualisation of partial participation, which indicates that patients' behaviour is one of co-operating with health professionals and adopting a passive role.

Fifty five per cent (55%) of users want to be involved in decision making to a certain degree and 18% were not keen. Reasons for not wishing to be involved at

all could be multifactorial. It could be, as already indicated, the presence of a knowledge gap, where users see themselves as simply complying with whatever care is provided. This perpetuates the notion that the doctors are in charge, with nurses following the instructions of the doctors, in a hierarchical structure (Lindow 1990). Surprisingly, however, in response to “to what extent users would wish to be involved in decision making,” only 27% indicated that they would like total involvement. It could be the prevailing culture of medical dominance that users still expect their input to their care as minimal.

The health professionals, although very supportive of the ideas of users being involved in decision making about their care, were cautious and warned that care has to be taken in order not to generalise. Active involvement in decision-making is dependent on the “stage and type of illness” that the patients suffered from. One staff member commented

“I agree with patients being involved in decision making about their care but too much knowledge could be dangerous; a process is required for effective co-ordination”.

It is evident from the findings that MHS users would wish to be part of the decision making process even in circumstances when the health professional decides on the care. Those decisions should be based on the patient’s contribution and choice. Clearly strategies should be implemented so that their voice is heard, conversely it should take into consideration the view of those who are willing for the health professionals to exercise the power to make decisions.

A large number (60%) of MHS users felt that the organisation of the care setting enabled them to participate in their care. Just less than half of the respondents felt they had no control over the care and found the organisational arrangement did not help facilitate their exercise of control. Health professionals may have to give up a degree of power and control, in order to facilitate a non-hierarchical communication level. This would entail MHS users being engaged at the intellectual level with health professionals hence it could empower users.

The health professionals tend to focus on their own agenda instead of that of the

user. The control of power may change by involving patients in their care. Although this approach may cause distress in health professionals (Peplau, 1988) it can be argued that holding on to power could give a psychological protection to the health professionals. This is reflected by Meyer (1993) who found the health professionals were not particularly committed to user involvement in decision making about care. The findings of his study show that MHS users felt they were in control of care while most research studies show the opposite. It could be the users were affirmative for fear of being labelled in a negative way (Stockwell, 1972) or provided responses socially desirable to the researcher.

The findings suggest that mental health nurses must respect the MHS user as knowledgeable about their own condition (Clark, 1987). In order to achieve this, social equality has to prevail where self-determination and mutual responsibilities of both the nurse and users, are recognised and acknowledged (Murray, 1997).

When users' views are sought they commonly claim that the health professionals have not listened to their opinions and their concerns are disregarded (Robinson, 1996). It could be, however, that MHS users who generally feel in control and express positive attitudes would be assertive enough to demand control over their care. There is a general understanding that patients with positive attitudes, who report higher level of control over their care, are those of a higher social class, and most knowledgeable about their condition, younger and familiar with the hospital system (Brooking, 1980). This is true of the non-manual MHS users in this study. Because of their social background they may strive to be in control of their care.

For the health professionals to exercise control is still generally accepted and in some cases found desirable by users who derive psychological security from the knowledge that the health professionals are in control. The findings in this study are congruent with that of Strull et al (1984) who found that the clinicians believed that the patients would want to participate in their care. In reality only

52% of patients actually wanted to participate (Strull et al 1984).

5.3 Social Environment.

For the purpose of this study, the social environment encompasses relationships between the MHS users and health care professionals, in which there is mutual understanding, respect for and value of each other's contribution of ideas.

The findings show a negative attitude towards the social environment but, when looking at the collective response, there is a weak positive perception toward the social environment that would not adequately facilitate collaboration or encourage the shared decision-making process. A social environment in which the users are not encouraged to be independent and where decisions about care are made exclusively by the health professional can create user dependence on the health professionals (Brownlea, 1987). Within this social environment users tend to follow instructions in order to be 'good patients' (Kelly and May, 1982). A dependent role of users enables the health professionals to maintain practice grounded in principles of task-orientated approach to care instead of evidenced based personalised care. Individuals usually respond favourably when they are involved in the care partnership (Favod, 1993).

Fifty-four per cent of the respondents disagreed with the statement that suggests the MHS users be treated as equal partners. This implies that MHS users do not perceive themselves as part of the care team. However, Brearley (1990) states that patients will not feel themselves to be on the same hierarchical level as health professionals. This perception might stem from the traditional perception of "them and us" relationship. If MHS users do not see themselves as part of the team they are not likely to feel confident to challenge or suggest improvement to their care.

Investigating hospital experience of MHS user in-patients McIntyre (1989) found that MHS users disliked attending ward rounds, an activity whereby every member should feel part of the multi-disciplinary team. Conversely the MHS

users are more likely to participate in activities they perceived as useful in which to have a say, as opposed to those merely deemed to be so by health professional (Sharma et al, 1992). This indicates that perhaps users are not keen on activities in which they have to collaborate with a number of health professionals, at the same time, (such as during the ward round). They are more likely to express how they feel on an individual basis.

A relationship that fosters a collaborative alliance is more likely to involve health professionals listening to the views of users because collaboration involves listening. Surprisingly 73% of the user respondents agreed with the statement "Health professionals ignore my views about care". From this result it can be inferred that if health care is a co-operative venture, then all parties involved in the care process should at least have equal input. That calls for listening to others' contributions during a discussion.

Not taking users' views seriously with regard to care fosters reduced confidence in their contribution. Chamberlain (1988) endorses this by recounting that hospital experience makes users question their own judgement about decisions they make and consequently they lose belief in themselves. Listening to users' views is itself a psychosocial skill that strengthens the user-health professional relationship. It demonstrates that the health professionals accept and respect the user as a person who has a valid contribution to make to his own care.

A facilitative social environment entails awareness of and empathy for the users' views. Empathy is a fundamental component of nurse-patient relationship, built on genuine sense of respect for another human being (Stuart and Sunden 1995). It is unfortunate that MHS users often state that nurses do not always listen to or empathise with, their needs (Murray, 1997). There appears to be minimal nurse/patient interaction within mental health nursing because the nurses may be absorbed in administrative tasks, so that MHS users communicated mostly with unqualified junior staff (Sullivan, 1997).

The health professionals lack the personal experience of a problem, which might facilitate their understanding of user's perspective (Donovan, 1991). Perhaps the

professional status of the health workers has instilled a belief that they know what is best for users and thus unwittingly may ignore users' real views about their problems.

Seventy one per cent (n=39) of mental health users in the current study agreed with the statement "I feel I'm not in control of the care I'm receiving". This perception is congruent with Henderson (1997) who identified three conceptualisations of participation, one of which was partial participation whereby the nurses believe that they should take control because as patients are in hospital to recover from their illness. The rationale for adopting this stance is related to the assumption that patients "lack medical knowledge" (Henderson (1997 :p279). The patients in Henderson 's study (1997) echo the same sentiments that 'nurse knows best' so that nurses should take control of care. The perception is promoted by the traditional hierarchical relationship, which results in a child-parent, predominantly paternalistic relationship with the MHS users being passive recipients of care. Lindow, (1992) relating to her experience as a MHS user found the health professionals were reluctant to support her wishes to help herself by not taking medication. Invariably she felt that she was not in control of her care and decided that in order to save herself she had to stay away from the mental health service.

Interestingly the health professionals response to the same statement was mixed, with 47% (n=8) indicated that they agreed with statement and another 47% (n=8) unsure of whether patients are in control of their care. It can also be inferred from this result that the notion of implied consent when patients are hospitalised appears to promote a "you do as you are told approach" in a relationship. Not questioning care or lack of control can be seen as a characteristic of patient's behaviour.

The rigid culture of a hierarchical relationship can negate the philosophy of partnership and uphold an ineffective social environment. A number of studies have found that generally, the health professionals, particularly nurses, maintain the ideology of perceiving patients as submissive, passive recipients of care,

(Armitage, 1981: Hewison, 1995 and Saunders, 1995). Despite calls for involving patients in care, in reality nurses still focus on nursing tasks that limit their social equality in a user and health professional relationship. The nurses still exercise virtually total power and control over patients who thus might feel vulnerable (Hewison, 1995).

The findings reveal that both health professionals and users are of the opinion that patients are not encouraged to question care. This could be due to the medical discourse that predominantly underpins and drives the care process including the type of relationship that occurs between the health professional and the users. The belief that patients are there to get better, places an emphasis on guidance and co-operation with any instructions. Indeed, very ill and older patients would appear to prefer this pattern of relying on health professionals for total care, including control of what happens to them whilst they are hospitalised.

The agreement with the statements (I feel I'm not in control of the care that I'm receiving) implies that medical discourse focuses on the diagnosis and treatment. This discourse discourages the acknowledgement of patient strengths. The failure to encourage patients to ask questions of health professionals was seen by Morrison (1994) as another facet of hospital culture. It stands to reason that if users are to assume greater responsibility over their health, as espoused by the socio-political trend, then the social environment must be such as to encourage actively users to ask questions in order to gain information to enable them to collaborate and participate in health care activities.

Seventy three per cent (n=40) of MHS users responded affirmatively and 71% (n=12) of the health professionals disagreed with the statement "I am not well enough to be involved in planning my care" The users' responses to the statement concur with Biley (1992) who found that the level of patients' participation in decision-making about their care was detected by how physically fit they were, "Being too ill" was seen as a reason for not being involved.

Brody (1980) too suggests that patients who are seriously ill may be comforted

by the knowledge that health professionals are providing quality care and thus not participate in the decision making about care. Szasz and Hollander (1956) model of participation (quoted by Trandel-Korenduck, 1982) maintains that in the activity-passivity model, the health professional makes all the decisions and the very ill patient adopts a passive role. Similarly the conceptualisation of exclusive participation proposed by Henderson (1997) showed that respondents mirrored the notion that the patients are unwell and consequently could not be expected to partake in any decision-making process.

However, the staff respondents in this study indicated that they disagreed with the statement, assuming that users can still be involved. For example, nurses asking patients to assist and co-operate in activities of daily living felt that they might view this as constituting participation in care. The users may allow choices to be made for them because of lack of knowledge. A body of evidence seems to suggest that it is the lack of knowledge or competence gap that precludes active patient collaboration. Some users may hold these views because of being in a hospital environment, accepting the sick role (Parsons, 1975).

It could be that they are so helpless and disempowered and cannot concern themselves about any relationships that foster collaborative practice, but instead prefer to leave it to the health professionals who have the medical knowledge. Indeed Illman (1991) has even suggested that a modern perception of the patient role is that of an active consumer. This study has shown how users wish to be active participant and if a user were truly a consumer he/she would be given appropriate information to make informed choices.

Health professionals' responses to the same statement "nurses/doctor know what is best for patients" were mixed. The view that nurses/doctors know best is not uncommon, patients traditionally have perceived the notion that health professionals are experts, and always furnish them with the right information. They may not know what they need in the first place or not have the motivation to assess the care they have received believing that the doctors know best

(Illman 1991). However the knowledge health professionals have may consist only of medical treatment and this ignores the fact that users' own experiential knowledge is just as important.

Clearly the negative responses to the statement "all decisions about care should be taken by health professionals" demonstrate a desire on the part of users to collaborate. This is consistent with findings of some of the studies that have presented conflicting information. Henneman et al (1995) remarks that collaboration is a complex concept. Glenister (1994) concludes that service users would wish to participate in decision making while Strull et al (1984) report that some patients preferred the clinicians to make the decisions for them.

Comparison of common items (users and health professional) listed on the Likert-scales showed that the former held a negative view towards the social environment while the latter was slightly positive. However analysis of individual scores showed that a majority of users agreed with most of the negatively worded statements indicating a marginally negative attitude towards the social environment.

5.4 Summary of the Discussion.

The chapter has discussed the findings of the study. What has transpired is lack of universal consensus as to the exact role of MHS users, in working together with health professionals. There is lack of consensus in the conceptual understanding of the meaning of CCP between the users and health professionals and among health professionals. Only a small number of MHS users had come across the term CCP in practice.

Analysis of data revealed that MHS users believe health professionals should work with users to decide on care, which is consistent in the main with the WNB (1994) idea of CCP. The emphasis is on working together at an intellectual level as opposed to purely engaging in a physical activity. It involves notably discussing and negotiating and exchange of ideas but also co-operating with

others' ideas. It is possible that although the MHS users had not come across the term theoretically, in reality it might be present in an implied manner. However, the process of working together to plan care is supported by a majority of the respondents.

In order for CCP to work efficiently an understanding of the concept of collaboration is crucial. As the literature revealed collaboration is more than simply involvement in decision-making. There is a need for assertiveness and co-operativeness of each person's ideas, which contribute to a decision. With that in mind collaboration becomes a psychosocial skill that needs to be learnt by both MHS users and health professionals in order to avoid ambiguity and conflict of roles.

Because of lack of consensus of what constitutes patient collaboration the concept has become operationalised in a variety of ways. Generally, it is used interchangeably with other related concepts such as involvement, participation and partnership not necessarily implying equality. Pressure for the promotion of collaboration between users and health professionals is increasing in the absence of a clear definition (Welsh Office, 1998). Patient collaboration in planning care cannot be assumed to be an approach that is commonly understood by MHS users and health professionals.

The users perceived "seeing their records" as the most important aspect of working together. It can be argued that this stance is in keeping with the belief that patients have responsibility over their health as a result of increased awareness of consumer rights (Cahill, 1996). The care pathways may be an ideal way to offer the user an opportunity to see and contribute to care plans. Generally it would appear that users prefer to work together with health professionals, while professionals, although they acknowledge the importance and positive impact of involving patients, still appear to prefer users to be passive recipients of care.

From this research, the findings suggest a discrepancy in what is being espoused

and what is actually found in practice. The findings demonstrate a preference by users to participate in the decision making process in their care. However, the results reflect the confusion present in the literature, some users preferring to be involved in collaboration, whilst others would not look for active involvement/collaboration/partnership.

The health professionals in the study endorse MHS users' participation in decision-making about their care. One health professional was sceptical about the idea of equipping users with sufficient knowledge fearing that, "little knowledge may be dangerous". This perspective militates against the current political trend of the ideology of public involvement in services pertinent to them. The climate of public involvement is such that health professionals need to look at ways of genuinely involving users in collaboration. One way could be to modify the attitude of both the users and health professionals in order to adopt social environment that fosters a horizontal style of communication, which lends itself to a collaborative process.

Health professionals relinquishing some power and control, and empowering users by allowing and encouraging them to be more responsible for their own care can rectify the issue of lack of control of care. This calls for communicating with them to elicit their preferred ways or mechanisms of enabling them to take control of what is happening to them. Lack of control in care is incongruent with social equality. Changing the nursing ideas and social environment for the benefit of users and health professionals can challenge the imbalance of power. This may be achieved by implementation of a more humanistic model of care that considers the whole person. In addition, a social environment that empowers, where there is respect opposed to a relationship based on "them and us" approach to decision making, can be said to depersonalise the user.

Because health professionals are immersed in the traditional manner of delivering care, they may not recognise the effects the practice has on users. Openness and transparency of care activities between health professionals and users will ensure trust and confidence to question care. This is being encouraged

through the use of clinical governance (Welsh Office, 1998). It is assumed that this will ensure that standards of care are monitored, to meet the standardised expected criteria of quality of care. MHS users will need to be able to talk to health professionals about the care they are receiving without fear of being labelled as difficult. The perceived negative social environment calls into question the nursing philosophy of holistic care that is commonly embraced by many of the care setting philosophies.

Most of what is available as revealed in the literature is an anecdotal or a theoretical discussion of collaboration in decision making of care. Therefore, there is a need for further research utilising a triangulation of methods, where possible to observe collaboration in reality. Observing events such as ward rounds or some multi-disciplinary activities where MHS users contribute to the discussion related to their care will enable researchers to assess the level of collaboration taking place.

The remit of this study did not extend beyond the established conceptual understanding of the meaning of CCP and aimed to discover health professionals' and MHS users' views on decision making which, for the purpose of this study was seen as integral to CCP. In view of the numerous calls and debates on users involvement in collaborative relationship, in the decision making process, it is imperative that health professionals modify the social environment, creating one that fosters a humanistic caring, promoting shared responsibility and horizontal interaction with users. In this way, any discrepancy between what users and health professionals perceive as CCP may be reduced.

For the social environment to accommodate the MHS user the health professionals will need to relinquish some power, control and authority, to enable users to be co-workers (Donovan 1991). Therefore, the role of being facilitator and empowerer will help the users to be more responsive to the changes in the health care system. If the aim of relinquishing control is not fulfilled, possibly role conflict may result with the user remaining in the passive role.

Patient collaboration calls for patients to demonstrate willingness to take an active role and, assume a degree of power. In order to achieve this information has to be accessible in language that is understandable to them. The chances for participation will only occur if those involved have a common understanding, and share a common language (Barker 1997). Similarly CCP has to be understood by both partners in the health care context.

5.5 Limitations of the Study.

The findings cannot be extended beyond the population studied; the sample was small (n=72). Although a self completed questionnaire is ideal as a way of sounding concepts, on reflection some of the questions might have been too broad, particularly with reference to decision making about care. A generic way of eliciting views from users and health professionals was rather limiting. Probably future research should focus more on a specific aspect of care that involves decision-making, for example transfer or discharge plans. This would facilitate the development of a tool to measure the existence of collaboration.

At the commencement of the study, very little information related to CCP was available. The small amount of literature available covered mostly descriptions of the process and the outcomes of collaboration. It would appear that in Britain the perception of CCP was different from that held in U.S.A. None was apparent in mental health care system until recently when alluded to integrated pathways (Jones 1998). Now there is a growing amount of literature focusing on CCP taking place in integrated care pathways (Walsh 1998). This is in concordance with the American view, that is, use of critical pathways. Critical pathways would appear to be the tools, which facilitate collaboration.

The study did not set out to establish whether CCP was being practised. Probably future research should identify a clinical setting that is practising CCP, using, and a tool to measure its existence, to determine further what the new role of the MHS user in CCP should be. This is especially needed because CCP is increasingly becoming an accepted ideology in contemporary nursing practice.

Chapter Six

- Introduction
- Main Findings using Critical Incident Technique
- Conclusions

CHAPTER 6

CRITICAL INCIDENT TECHNIQUE (CIT) USED IN THE SECOND QUALITATIVE PHASE OF THE STUDY

6. Introduction

Following the analysis of the questionnaire data there appeared to be value in further examining the shared conceptual understanding of CCP. Thus it was decided to use a qualitative approach to interview 15 subjects (ten MHS users and five health professionals) relating to their use of CCP. Critical incident technique (CIT) as a theoretical framework was employed to guide and analyse the interviews carried out with the MHS users and, a semi-structured interview format with health care professionals. The choice of using CIT was to facilitate the understanding of particular phenomena that the users would recount from their experience of involvement in care (Flanagan 1954). The interviews with the MHS users and health care professionals were carried out to focus on the actual practice, looking at how interactions between MHS users and health professionals normally take place. The areas for exploration included: collaboration, decision-making, power, control, equality and helpfulness, which formed the basis of the questions. This part of the study is attached as appendix five as space does not permit its inclusion here. However, the main findings from the interview data analysis are as follows.

6.1.1 Main Findings

Thematic analysis revealed four themes; these were grounded in the users' words. They included **"Coercion, not care", "Have no power", "Paying lip service"** and **"know it all"**. These themes demonstrate very little involvement in decision-making even though they demonstrate a range of relationships between the MHS users and health professionals

In-depth critical incident analysis was carried out. Four themes emerged these included **"incidents not incidents", "involved-non involvement", "imbalance of power",** and **"contextual factors in involvement"**. The critical happenings

were considered to be the basic units of analysis. The critical incidents revealed an absence of CCP, from the users perspective. What emerged from the incidents was a repertoire of qualities that users perceive as admirable and valued when displayed by health professionals. The qualities identified are positive in encouraging a relationship which can be argued would facilitate collaboration.

The critical happenings in the incidents do not reveal the role the users played in decision-making. The incidents show minimal involvement in some cases despite the controlling relationship exerted by the health professionals. The opportunities to develop collaborative relationships were not always available. Those who did participate in planning care did not feel their views were taken seriously culminating in a state where they felt not valued as patients. Users can be empowered by embarking on social processes that promote and develop users' abilities (Weaver and Wilson, 1994). Those social processes need to be transparent and able to satisfy individual's expectation about their role in health care.

A majority of incidents indicated 'critical happenings' that denoted very little involvement of users in planning care. The health professionals perceive involvement in care differently, arguing that involvement was dependent on intrinsic factors such as the users' well being or age. Overall, the health professionals claim that users are encouraged to partake in decision-making but they acknowledge that a forum such as the ward round could actually intimidate users.

Some 'critical happenings' showed that users were not involved in care or decision making yet in fact perceived the happenings as positive because of the kind of support and qualities displayed by the health professionals. Those that the users could not identify as either positive or negative were assigned a category of 'other'. The meanings were not well articulated, but were of importance to the users. For effective involvement to take place in planning care, it would appear that the prevailing traditional culture would need to change to accommodate the new image of the user in health care system (Walsh, 1998). The emphasis is on health professionals developing interpersonal skills within a facilitative social

environment. This may help users to work towards a co-operative relationship that has benefits for both user and health professionals.

Findings from the critical happenings reveal very minimal collaboration between MHS users and health professionals. In addition the incidents seem to suggest that the social environment could be conducive to working together if certain qualities in health professional, such as those of friendliness and supportiveness, were present. The critical happenings contained in the incidents related to involvement in care, failed to provide a clear picture of the role of the user in decision making about care. Some critical happenings showed a degree of involvement despite a hierarchical-and controlling relationship.

Despite the desire to be actively involved in the decision making about care, users have not articulated how this could be achieved. The users also expressed a wish to see what was written about their care. The feeling seems to be that the MHS users wish to know what is written about them, not necessarily to make any entries themselves. Equally the health professionals concur with the idea of the users seeing their records instead of making an entry in the care plan. It was interesting to note that the occupational therapists have already achieved this ideal. Health professionals, though not specific about the qualities that are conducive to working together with users, concede that good interpersonal skills and a change of attitude and culture would support a working together approach to care.

6.1.2 Conclusion of CIT.

It was hoped that through using the CIT the MHS users would identify the role they played in deciding their care. This would indicate to what extent MHS users' contributions to care were valued and furthermore determine what strategies could be adopted to ensure genuine participation in any decision-making process. It would also explore the form of social environment that would be conducive to promoting collaboration of care.

MHS users require some social processes that enable them to partake in care planning, if they so wish. Users may be enabled to have control over their care and responsibility for their lives. Generally the reality of what happens to the user in the care process is based on the reality perceived by health professionals (Avis 1995). This may be contrasted to the reality grounded in the values and beliefs of the users. The findings indicated that that the users perceived that their views were just as important as those of the health professionals.

Chapter Seven

- Conclusion of the Whole Study
- Implications of the study
- Recommendations

CHAPTER 7

CONCLUSIONS

7.0 Introduction.

The main conclusions of the study are discussed leading to the implications of the study. At the commencement of the study the term (CCP) had become an addendum to the vocabulary of the health and social professionals as a result of several government documents. These documents encouraged multiprofessionals to take account of the views of the users and the carers (“Working for Patients 1989”, NHS and Community Act 1990, “Working in Partnership” 1994, “Putting Patients First” and “Involving the Public, 1998”).

It is evident from the findings that user collaboration conjures different conceptual understanding between MHS users and health professionals, and even among health professionals themselves when applied within the health care context. The conceptual meaning of CCP, albeit articulated differently, encompasses a working together approach to planning and delivering care. The fundamental feature is the concept of collaboration.

The health professionals believed that CCP was practised in the care settings studied here. The form of CCP, they referred to, was different from that prevalent in U.S.A, which comprised a managed care system that commonly used critical pathways. The CCP enabled the health professionals akin to the diagnostic related group, to come together to formulate a sequence of care events to be carried out. The timing of carrying out these care events and the anticipated outcomes are stipulated in the care pathways.

Diverse terms are used to describe the same care pathways, these include; multi-disciplinary care action, integrated pathways, care maps and anticipatory

recovery pathways. Another component associated with a managed care system is the variance tracking. This is employed to audit planned care and their integrative solutions. Any deviation from the planned care is termed the variance (Walsh, 1998).

CCP, for the purpose of this study, entails the working together of MHS users and health professionals to decide on care. This is assumed to take place in a relationship of mutual understanding and respect where each individual's contribution is valued. CCP can be employed with any of the care frameworks such as case management, patient-focused or co-operative care systems. Of these frameworks case management appears to be commonly used in the mental health care system. Very little is known about the application and effectiveness of care pathways in mental health care systems (Jones, 1998).

The user does not appear to be directly involved in the development of the pathways. From the literature, it appears that the user is not explicitly involved as part of the team; which seems to suggest a professional orientated approach to care. However, with the current emphasis attached to their views about services that affect them, it is important that users are part of any discussion. It would appear to contravene the person-centred ideology if the predetermined outcomes are discussed without involvement of the user, even though the individual care plan is reported to reflect the multi-disciplinary care path (Alder et al. 1995; Walsh, 1998). Perceived positive outcomes associated with CCP have been highlighted (Finnegan, 1992; Lancaster, 1993; Ingram, 1995) in the absence of firm conclusive evidence.

What has transpired is that collaboration is more than a mere physical proximity. It includes an engagement in intellectual activity, in the sense that all participants have a common understanding of their role. The participants involved co-operate with each other and at the same time express their own concerns. Every one's contribution is valued and respected (Miccolo and Spanier 1993).

From the study there was no conclusive firm evidence of MHS users and health professionals working together as a rule to decide a plan of care. A large number of users had not come across the term CCP that may indicate that the MHS users were not informed of the type of delivery of care. It may be impossible for them to evaluate care that is provided if they are unaware of terms and the desirable standard of delivery of care. Indeed there is a broad view that users are often asked to evaluate care they have received but in most cases they have no knowledge of the acceptable and expected standard of care (McIver, 1991; Illman 1991; Avis, 1995).

Although users expressed a wish to participate in decision-making about their care, they were not clear how this could be achieved. New frameworks for consulting MHS users and health professionals are needed. Both participants could be drawn into a contract as another way of providing a genuine collaborative approach to care that is committed to involving the user. This would entail the MHS users' perspective being taken into account, as both sides would have to meet their side of the contractual agreement. One of the findings of this study indicated how the users would wish to see their records; thus having a contract would accommodate the wishes of all the MHS users even those who are too ill or reluctant to participate. Application of contracts would ensure that the principles of collaboration were applied in reality. The MHS users would inevitably be involved in every stage of a care delivery that would then reflect their experiential knowledge.

MHS users revealed factors that impinge on effective user collaboration. Interpersonal distancing precludes effective user collaboration because it tends to leave inexperienced, unqualified staff attending to the user while the senior staffs absorb themselves in administrative tasks (Robinson, 1996). The medical view influences the kind of delivery of care users receives, and may be said to foster a relationship that pays more attention to the diagnoses than to the personhood (Horsfall, 1997).

The users viewed care purely as administration of medication; it can be argued that such ideology seriously limits the user sense of competence, control and responsibility. Their vulnerabilities may be misunderstood, which was evident in the findings revealed by the incidents where there was no consideration as to the best option for the user to choose in order to solve their problems. MHS users perceived the social environment as controlling and hierarchical, not always best at offering humanistic care. Promotion of social equality in the health care context requires a change of culture, attitude and different perception of each other's role.

The critical attributes of collaboration that emerged in the analysis are not very different from those highlighted in the literature. What transpired was the identification of the personal qualities of health professionals that users felt would promote a much closer relationship; qualities that are consistent with the humanistic care as advocated by Rogers (1980).

The 'critical happenings' contained in the critical incidents demonstrated that users had no control over their care in the health care setting. They were not involved in any decision-making process regarding their care plans, which could be seen as part of socialising them into 'sick role'. The findings, however, suggest that users would wish to take more control over what happens to them. To help them achieve that, the health professionals may have to relinquish some power and control, and be prepared to share. This calls for a different perception of the role of the user and the health professional.

Users largely felt that they were not involved in decision-making. In contrast, health professionals claim that the MHS users are involved in decision-making arguing that, if they were opposed to the decisions made about their care, they would not concur with them. There is a body of research evidence that confirms patients will "toe the line" (Waterworth and Luker 1992) for fear of being labelled unpopular or they tend to follow care unquestionably "do as you are told" not to cause any trouble.

The health professionals also believe that some patients, particularly the very ill and the elderly, are more likely to take a passive role in decision-making. They concede that “things are changing” because MHS users are more enlightened as to their rights. Both MHS users and health professionals appear to suggest a cultural change involving the acceptance of users as equals. It would ensure active participation in shared decision making.

MHS users have referred to their perceived position in the health care structure as being at the very bottom of the ladder. Information is usually seen as descending from the consultant to the nurses. The culture of how patients are treated, and above all, the attitude of nurse may have to change to foster the idea of seeing a ‘user’ as an instrument of change and co-partner.

The findings reveal that the social environment experienced by users was not generally conducive to CCP. The absence of user contribution to the decision-making related to their care, not being afforded equal recognition, and the existence of a hierarchical relationship, probably negates any promotion of user participation in care.

7.1 Implications of the Study.

The overall findings of the study are important for research, clinical practice and education for the following reasons:

Research

1. There is no universal conceptual understanding of the meaning of CCP, the study has revealed that the MHS user involvement in planning care is very minimal. For future research, utilisation of a large population and rigorous methodology should illuminate the role of the user, if a collaborative care approach is to be the norm.
2. The study has added support to the movement for the inclusion of MHS users

in research studies dispelling the question of MHS users being unable to provide irrational responses due to their mental health state that has tended to deter researchers from involving MHS users in research. This research has indicated that having a mental health problem does not necessarily mean the individual is incapable of describing his/her own experience.

3. . In most studies social environment has not been well examined and articulated as such. Findings of the questionnaire revealed an ambivalent position although there was a tendency towards negative views of social environment depicted by the results of the Likert scale. Further studies with MHS users are required in which critical social theory could be used as a framework. This might lead to modification of the social structures that the users found negated involvement in care planning.
4. The study has shown that MHS users are not aware of the term CCP, and the health professionals differ in their understanding of the concept. What may be valuable in the future is for researchers to explore the concept of collaboration in the reality of practice using different methods. For example observational technique in combination with interviews and questionnaire.
5. An action research project could be conducted to examine the use of “care plan contracts”. CCP would be inherent and observable in the process. It is important to employ a terminology familiar to both MHS users and staff.

Clinical Practice

1. For decision making processes to reflect the MHS users’ needs; the social environment, that is seen presently as paternalistic and controlling compounded with lack of availability of information, will need to change in order to accommodate the patient collaboration ideology that is being promoted by successive government documents (Putting Patients First, 1998; Involving the Public, 1998). A controlling and disempowering social environment hampers any friendly, understanding, collaborative relationship.

2. Although the critical incidents did not explicitly demonstrate all the attributes Of collaboration, the MHS users benefited more from the health professionals who showed qualities that reflect client-centred approach (Rogers 1980). Thus, these attributes should be fostered in clinicians.
3. Listening to MHS users' concerns, regardless of their mental status appears to Be something that the mental health professionals need to address and connect themselves more with users. Interpersonal distance militates against application of collaboration. Where the user is too ill to express their wishes the health professionals may have to overcompensate until such period when the user can cognitively function with minimal help. Communication with users is central to the helping process in mental health care.
4. The health professionals should be aware of each other's role including that of that of the MHS users in order to work as equal partners.
5. The findings of the study have demonstrated that in practice MHS users view care as essentially medically driven which shows the strength of the psychiatric medical ideology. Humanistic care is what the professionals were advocating yet the MHS user sees it differently. There needs to be a synchronisation of what health professionals and users feel is humanistic care as opposed to diagnosis and treatment driven care.
6. Because of the emphasis on clinical effectiveness and a wish to actively involve users, this study has shown the importance of using a common language especially in which the users' experience will be an integral part of assessing the standard of care. The new National Institute for Clinical Effectiveness will be facilitating drawing up of guidelines of which will make use of users' views of care (Iskander 1999). Without adequate educational preparation health professionals may find patient participation in deciding about and evaluation of care threatening (Meyer, 1993; Iskander, 1999)).

Education.

1. Education of health professionals in the necessary interpersonal skills required to promote collaborative relationship is vital.

7.2 Recommendations

- The concept of collaboration needs to be tested, in the reality of practice, using different methods where a user is expected to contribute to care plans e.g., nurse-patient collaboration, multi-disciplinary meeting, ward round and care pathways. The methods could include a participant observational approach and, care plan document analysis and use of contracts. This would demonstrate the extent of user contribution in the decision making process.
- A rigorous research study is needed to sample a large population from all aspects of mental health care, to determine the extent of CCP and the general understanding of the concept and how they would wish it to be implemented. A study is needed to develop a tool that measures the existence of collaborative practice in any care setting. This might eradicate the perceived notion of engaging users as tokenistic, or care providers 'paying lip services'.
- Health care professionals need training to develop team building, facilitative group work and interpersonal skills in order to enhance the collaborative relationship. In order for CCP to be the norm, nurse education has a role to play in equipping the students with knowledge, attitude and skills that are essential for promoting the concept of user collaboration in practice. Promotion of interprofessional collaboration in education including users' perspectives, can only enhance the understanding of the user as an active collaborator.

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Appendix 1: Letter/consent

Dear

I am a registered nurse teacher undertaking a Research course and am seeking your views in order to improve the quality of care that patients/clients receive from the Mental Health Service.

Many people feel it is important that patients should take part as equal partners with professionals (i.e. doctors, nurses, social workers, occupational therapists and others) in planning their own care.

I would be grateful if you could spare a few minutes to give me your opinions by answering these questions. Your answers will be treated in the strictest confidence. Please would you return your completed questionnaire by the 21st March 1996 in the self addressed envelope provided.

Thanking you in advance for your assistance.

Yours sincerely,

Elizabeth Williams

✂.....

PATIENT CONSENT

Taking part in this survey is voluntary. If you do not wish to participate, it will not be held against you nor will it in any way interfere with your care and / or your treatment.

Confidentiality will be respected throughout the survey. No names or information will be disclosed to me without your prior consent.

Please indicate your willingness to complete this questionnaire by deleting accordingly.
I am willing / not willing to complete the questionnaire

Sign

Date

Thank you in anticipation

Appendix 2: Questionnaire

1. Please indicate by a tick, how long you have been attending the day hospital

- | | |
|--------------------|--------------------------|
| Less than 6 months | <input type="checkbox"/> |
| 6-12 months | <input type="checkbox"/> |
| 13-18 months | <input type="checkbox"/> |
| 19-24 months | <input type="checkbox"/> |
| More than 2 years | <input type="checkbox"/> |

2. Have you ever been an in-patient in a Psychiatric hospital?

- Yes ☒
No ☐

3. If yes, how long ago were you last in hospital?

- | | |
|-----------------------|--------------------------|
| Under 1 month ago | <input type="checkbox"/> |
| 2-6 months ago | <input type="checkbox"/> |
| 7-12 months ago | <input type="checkbox"/> |
| 13-18 months ago | <input type="checkbox"/> |
| More than 2 years ago | <input type="checkbox"/> |

4. Are you Employed? ☐
 Unemployed ☐
 Retired ☐

5. If you are in work, or used to work, what do/ did you do?

6. What is your age? Please indicate by a tick.

- | | |
|-------------|--------------------------|
| 20-29 years | <input type="checkbox"/> |
| 30-39 years | <input type="checkbox"/> |
| 40-49 years | <input type="checkbox"/> |
| 50-59 years | <input type="checkbox"/> |
| 60 and over | <input type="checkbox"/> |

7. Are you male ☐ Female? ☐

The following questions refer to the issue of health professionals working with patients to plan their care.

8. Have you ever come across the term “**Collaboration in Care Planning**” used in hospital ward or Day hospital?

Yes ☐ No ☐ Don't know ☐

9. Please indicate by a tick () whether you agree or disagree with the following statement.

	Agree	Disagree	Don't Know
Health care professionals should work together with patients in planning their care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. If you were going to be involved in planning your own care, what would you consider to be the most important things for you? Please tick four (4) number them 1,2,3,4 in order of importance.

- i) Sharing information with health professionals in a meeting ☐
- ii) Health professionals listening to my views about care. ☐
- iii) Being given the opportunity to be involved or not involved in my care. ☐
- my care. ☐
- iv) Co -operating with health professionals' views about my care. ☐
- v) Being able to see what is recorded about my care ☐
- vi) Any others, please specify

11. The general trend in mental health care is that patients should take part in the decision-making of their care.

Would you like to be involved in deciding your care?

Yes ☐

No ☐

12. To what extent would you like to be involved in the decision-making of your care?

Totally involved ☐

To some extent ☐

Not at all ☐

13. *If you do wish to be involved in decision making of your care, how would you like this to happen? Please choose one*

i) Deciding together with health care professionals the care that I require ☐

ii) Health professionals making decisions but considering my views. ☐

iii) Discussing my care with health care professionals and me personally making the final decision. ☐

iv) To be given sufficient knowledge about my health needs to enable me to decide ☐

v) Don't know, please state why

-
14. Do you think that at present you have as much control over your care as you would want?

Yes ☐

No ☐

15. In your opinion do you think the way the Day hospital? is run helps you to work together with health care professionals?

Yes ☐

No ☐

Don't know ☐

Please indicate your degree of agreement/disagreement with the following statements

	Statement	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1	The staff encourage me to be independent					
2	Health professionals ignore my views about care					
3	I'm treated as an equal partner with health professionals.					
4	I feel I'm not in control of the care I'm receiving.					
5	I should be allowed to see my care plan					
6	I'm not encouraged to question my care.					
7	Patients are consulted at each stage of their care.					
8	I am not well enough to be involved in planning my care					
9	Patients should be given more respect by health professionals					
10	Nurses/doctors know what is best for me					
11	As a patient I do as I am told without questioning					
12	All decisions about my care should take by professionals without my involvement.					

Please feel free to make additional comments.

Thank you for sparing your time to answer these questions

Appendix 3: Letter to the staff

Dear Colleague,

Re: Collaboration in Care Planning

I am currently undertaking a Research Degree Course at the University of Glamorgan. For my thesis I have chosen to focus on Collaboration in Care Planning. I would be grateful if you would be kind enough to spare a few minutes to complete the questionnaire.

All information received will be treated in the strictest confidence and, anonymity will be fully respected. Please return the completed questionnaire in the envelope provided by no later than 21 March 1996.

Thanking you in advance for your assistance.

Yours sincerely

Elizabeth Williams
Lecturer

Appendix 4: Staff Questionnaire

1. Please indicate by a tick your professional group

Nurse	<input type="checkbox"/>
Doctor	<input type="checkbox"/>
Occupational Therapist	<input type="checkbox"/>
Physiotherapist	<input type="checkbox"/>
Other (Please state)	<input type="checkbox"/>

2. What is your present grade and/position?

G	<input type="checkbox"/>
F	<input type="checkbox"/>
E	<input type="checkbox"/>
D	<input type="checkbox"/>
Other (Please state)	

3. How long have been in this post?

Less than 1 year	<input type="checkbox"/>
1-3years	<input type="checkbox"/>
4-6 years	<input type="checkbox"/>
7-9 years	<input type="checkbox"/>
10 years	<input type="checkbox"/>

4. How long have you worked on this unit?

Less than 1 year	<input type="checkbox"/>
1-3 years	<input type="checkbox"/>
4-6 years	<input type="checkbox"/>
7-9 years	<input type="checkbox"/>
10 years& over	<input type="checkbox"/>

5. The following set of questions refers to Collaborative care planning. In your opinion, what does Collaborative Care Planning mean?

6. Are you currently involved in Collaborative Care Planning

Yes

No

7. If yes, are patients involved in Collaborative care planning?

Yes

No

8. Do you feel patients are aware of the term Collaboration in Care Planning?

Yes

No

Don't Know

9. The general trend in Mental Health Care is that patients should be actively involved in deciding their care. What are your views about this trend?

10. To what extent do you think patients would like to be involved in deciding their care?

Totally involved

To some extent

Not at all

Please indicate your degree of agreement/disagreement with the following statements

	Statement	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1	Patients should be involved actively in planning of their care					
2	Patients are treated as equal partners with health professionals					
3	Patients are not in control of their care					
4	Patients should see their care plans					
5	Patients are not encouraged to question their care					
6	Patients are consulted at each stage of their care					
7	All decisions about Patients' care should be taken without their involvement.					
8	Patients should have a say in the running of the unit					
9	Patients are not well enough to be involved in deciding their care					
10	Patients should be given more respect by health professionals					
11	Nurses/doctors know what is best for patients					
12	Patients tend to do as they are told without questioning					
13	Patients are given the choice to be involved in their care					
14	Patients can complain about any aspect of their care if they are unhappy about it					
15	Patients are given enough information about their care to enable them to decide					

Thank you for completing this questionnaire

APPENDIX 5

CRITICAL INCIDENT TECHNIQUE

6. Introduction

This chapter offers a brief description of the qualitative approach underlying Flanagan's Critical incident technique (CIT) and, how it was applied to the present study. CIT is used as theoretical framework to guide this phase of the study. The interviews with the MHS users and health care professionals were carried out to focus on the actual practice, looking at how interactions between MHS users and health professionals normally take place. The areas for exploration included: collaboration, decision-making, power, control, equality and helpfulness, which formed the basis of the questions. To achieve the aim, a qualitative approach using CIT was employed with the MHS users and a semi-structured interview format with health care professionals. (It was felt that information could be gathered from health professionals without using CIT.)

The analysis draws upon some work of Norman et al (1992) and it also considers the limitation and implications of the CIT. The general aim of the whole study was to explore MHS users' views concerning aspects of working together as already stated in the introduction. This secondary section sought more information based on actual remembered care events.

The qualitative approach based on phenomenological philosophy describes how an individual experiences a phenomenon. The MHS user who undergoes certain experiences can articulate them. Phenomenology focuses

“ On individual interpretation of their experience and the ways in which they express them” (Parahoo (1997: p. 43).

Only those who have witnessed the activity either through direct experience or observation can communicate about it. The respondents in the study have described the phenomena to which they have been either exposed or have observed.

The study aims to understand particular phenomena that the MHS users would recount from their experience *of involvement in care*. The researcher is primarily instrumental in data collection and is interested in how respondents give meaning to their experience (Marshall and Rossman, 1989).

6.1 Flanagan (1954) and CIT:

CIT is a qualitative method of enquiry designed to identify, from interviewing patients/ clients, the causes of satisfaction and dissatisfaction about the quality of some aspect of care (Pryce-Jones 1993). Using CIT the respondents describe the incidents, either through direct observation or recall of the experience. Flanagan (1954) seems to prefer more direct observations of incidents. The observer narrates the incident retrospectively so that there is some form of judgement whether it is regarded as positive (good) or negative (bad) (Pryce-Jones 1993).

The incident does not always have to be an action; it could be a non-action, for example omission of care within the health care context. Flanagan (1954) suggests using five criteria to assess whether the situation could be considered as critical, these criteria are:

1. Is the actual behaviour reported?
2. Did the reporter observe it?
3. Were all relevant factors in the situation given?
4. Has the reporter made it clear just why she or he believes the behaviour was critical?
5. Has the reporter made a definite judgement regarding the criticalness of the behaviour?

The above criteria place more emphasis on the critical incident but what is more substantially important is the “happening” in the incident. In other words this is whatever the user reports to be happening.

6.2 Critical Incident Technique in Nursing Research

Describing patients' perception of quality of psychiatric nursing care, Norman and Beech (1994) employed an interactive interview to collect data. Using an interview guide they asked the same questions of each respondent; this provided a structure and ensured that respondents focused on the topic under investigation. With the assistance of the person-in-charge a convenience sample of 24 MHS users was drawn from two acute psychiatric admission wards. Adherence to the ethical requirement was met. The interviews were tape - recorded.

Analysis of data was by means of thematization resulting in five themes. Unfortunately, very little information is provided relating to details of thematization. That makes it difficult to evaluate critically or replicate the study with certainty. In total, 239 indicators emerged descriptive of high and low quality of care. These concepts are not operationalised to enable the reader to make a balanced judgement of the worthiness of the study (Parahoo 1997).

Norman and Parker (1990) used a focussed interview approach in their CIT study of psychiatric patients' views of their lives before and after moving into a hostel. They claim that the clients were co-operative and frank because one of the researchers was familiar with them. However, they fail to address the issue of social desirability that might have biased the narrations presented because patients rarely criticise care especially when they are still affiliated with an institution (Sheulds, 1985; May 1990).

To strengthen validity, the interviews were reflected back to the respondents for confirmation (Norman and Parker 1990) but how this was actually carried out is unclear. It is not stated whether all the interviewees received their own transcripts and what transpired in light of the feedback. This mechanism of ensuring truthfulness of data is essential and desirable (Silverman 2000).

Cormack (1983) employed a CIT postal questionnaire. The response rates of the health professionals, especially the doctors were very low (4% of 118 doctors). A classification system of incidents was utilised. The author acknowledged the difficulties presented by some incidents that could not be easily incorporated into the main categories. The study does not provide a detailed way of managing the unusable information, which does not fall into any of the assigned categories. Issues of validity and reliability are addressed through use of inter-rater reliability to test whether independent judges produced the same classification of categories as the researcher.

Using CIT to explore of nurses' perception of the psychological role in treating patients with physical problems in rehabilitation. Rimon (1979) observed the respondent performing a care task and then asked for examples of incidents related to the aim of the study. Rimon reported that some of the respondents were "unco-operative" depicted by the dichotomous responses to the questions. It would seem they were not providing detailed accounts of incidents, possibly because of the intrusive manner of collecting data. Those who were co-operative remarked on how difficult it was to produce an incident immediately. They may have felt pressurised to recount quickly an incident whilst attempting to carry out nursing duties.

Investigating what consumer's thought of care provided by Macmillan nurses, Cox (1993) used CIT to gather data from sample of 20 respondents through a semi-structured interview format. The CIT was seen as incurring huge benefits because it concentrated on specific incidents. The value of this focus on specific incidents is that not only does the respondent recall events but can also clarify feelings and meanings, which are associated with the event. The analysis involved coding and categorisation; the categorisation of data subsequently informed the role of the Macmillan nurse. Categorisation does not appear to have an analytic basis, and the reader has no ground to contest what happened because there are no data extract included, (Silverman 1993).

Critical incident technique has also been employed within an educational context (Clamp, 1980; Benner, 1984; Lin, 1997). The literature review reveals that CIT has also been employed with different user groups in a variety of health-related settings. The methodology of choice in most studies reviewed is a qualitative approach employing interview format, either semi-structured or focussed what other authors have called conversational style of interview (Beech and Norman 1994). There has been a degree of standardisation in order to focus on the issue under investigation. This has been achieved through asking the same questions of the respondents, probing was necessary for further clarification, (Norman and Parker, 1990; Cox 1993; Norman, 1994; Beech and Norman, 1994).

What also is evident is that the size of the sample population is not of great importance. What actually counts is the number of the critical incidents that become the basis of analysis.

Critical incidents analysed

The purpose of the analysis is to summarise and describe the

‘data in a sufficient manner that can be effectively used for practical purpose’ Flanagan (1954:355).

Using the critical incident as a basic unit Rimon, justified her decision to use categorisation stating that the “essential thing seems to be that the category system chosen is an obvious one” (Rimon, 1979: 407).

Categorisation of data appears to adopt a common sense approach in analytic thinking. Analysis takes the form of inductive categorisation of the information evidently portrayed in CIT studies (Norman et al, 1992). Different ways of analysing data are revealed in the literature. For example, describing the role of psychiatric nurses Cormack (1983) developed a simple classification system. In a study of patients and nurses' perception of quality of nursing care Norman (1994) employed critical happening as the unit for analysis, rather than critical incident as in Flanagan's case. Norman, (1994) argued that what is more

significant is the events that take place in the incident and the associated meaning. In this case it can be said detailed events from memory will meet the criteria set for critical incidents.

Analysing the incidents Rimón (1979) found that there was a duplication of incidents. These were eliminated because they did not fit into the categories. Moreover, the study does not indicate how the categories were arrived at. There is no evidence of subjecting the data to theoretical explanation. The advantage of using the concept of 'critical happening' is that it illuminates the events in the critical incidents (Norman et al, 1992). It can be argued that although Rimón found that there was duplication, different happenings would still be found. Moreover, every incident duplicated has some significance to the person experiencing it. There is no explanation of how the eight incidents were handled. In the current study the information that did not fit into any of the categories was classified as "other." The researchers who adhere strictly to Flanagan's criteria of incident tend to exclude the information from analysis as "dross" (Morse and Field, 1985). In contrast, other researchers include the unverified incidents in their analysis but fail to acknowledge that these have not met the criteria. Very little or nothing has been said about addressing the incidents that are not categorisable, the "dross".

More frequently information is given to describe the management of, and the procedure of analysing findings. Rarely is the theoretical underpinning of the categories discussed. It could be argued that what is important is that the categories are grounded in the users words and their world of experience. It becomes more difficult to evaluate what actually goes on in the interview, because in most cases the interview extracts are not presented, only an interviewer's summary. Most of the authors use a tape recorder to ensure accuracy and it helps to visualise the interviewee's non-verbal behaviour. Very rarely do the studies that use tape-recorder say anything about non-verbal behaviour of the interviewee. For example, the interviewee may be too anxious to recall the incidents and the interviewer can infer this from the behaviour

displayed.

The literature does not state the number of incidents that the interviewer should aim for. The number of the critical incidents depends on the matter under investigation. Norman (1994) discontinued the interview once the interviewee could not produce any more incidents. A hundred incidents per interview have been suggested (Flanagan 1954).

Norman (1994) provides a comprehensive method of analysis demonstrating what “happenings” entail. However it is not always clear whose interpretation of the happenings is used in the analysis, whether it is that of the respondent or interviewer? It appears that the author employed his subjective interpretation as well as, in some cases, the patient’s own meaning.

6.3 The Rationale for Choosing CIT

CIT was chosen to explore some of the perspectives that emerged in the questionnaire and identify the level of user involvement in care. Examination of these incidents, related to MHS users direct involvement in care, would illuminate critical happenings. It was hoped that CIT would exemplify situations in which MHS users were empowered and exercised control. In addition it should be possible to identify attributes of collaboration.

6.4 Procedural Stages in CIT

Flanagan (1954) suggest considering five elements when conducting a CIT study. These include:

1. Formulating the general aim of the activity
2. Setting plans and specification
3. Collecting the information
4. Analysing the information
5. Reporting and interpreting the findings.

Stages 1-3 will be discussed and related to the present study. Stages 4-5 will be discussed later.

Stage One: Formulating the general aim of the activity

The specific aim of this part of the study is to find out the behaviours displayed in care and describe the extent of MHS users' involvement with regard to the decision making process in their care.

Stage Two: Setting the plans and specification

This stage addresses the issue of who should be the observer and which activities should be observed or noted. Flanagan (1954) suggests that the observer should be chosen on the basis of familiarity with the activity. Additionally s/he should be able to describe it. The observers in this study are the MHS users who are familiar with the activity of care process i.e., interaction with the health professionals in the decision making process.

Stage Three: Collection of information

Gathering of incidents can be achieved in two ways: through direct observation or through actual experiencing of the incident and provision of a retrospective account (Rimon, 1979; Norman, 1994). With direct observation the researcher can observe the behaviour and report the details. In this current study the MHS users were asked to recall what they had observed or experienced and had subsequently made a judgement of the event in relation to their role in care giving.

6.5 Semi-structured Interviews

Interview technique was chosen to collect the data for the following reasons:

- It provided an opportunity to have face-to-face interaction with the MHS users allaying any potential anxiety (Appleton 1995).
- It provided an opportunity to put the respondent at ease through the use of effective interpersonal skills such as the way the author presented herself and the manner in which the study was explained (Appleton, 1995).
- It afforded an opportunity for the interviewer to explain any ambiguity and unclear questions (Parahoo, 1997) that the MHS users may have had.

Because it was a face-to-face interview, the interviewer was able to observe the reaction of the users. (If I asked an ambiguous question I could tell by their non-verbal cues and rephrase the question accordingly, which cannot be possible with the questionnaire, where the interviewer is absent).

- Higher response rates are common with interviews (Polit and Hungler, 1997) most of the MHS users, who were self-selected, and volunteered to be interviewed, attended, albeit after a few postponements of interview appointments. Motivation to attend the interview was high, demonstrated by the fact that the MHS users had volunteered to attend. After informal introductions the users preferred to be addressed by their first names, which reduced any communication barriers.

In addition awareness of the disadvantages associated with interviews helped the conduct of the interviews. Some of the disadvantages that the author considered included:

- Interviews can be costly and time consuming both in organising and travelling to the meet interviewees. All interviews took place in the community centre settings, which users frequented, and that reduced the time spent on travelling.
- There is a tendency for the interviewee to digress from the main theme by introducing their own issues of concern (Devaus, 1991), use of an interview schedule allowed for flexibility and at the same time, the respondents focused on the issue under investigation, hence imposing some structure to the interview process (Norman, 1994;Parahoo, 1997).
- One disadvantage that appears to be overlooked in most studies that use utilise interview format, is the anxiety on the part of the interviewer, because the interviewer and the respondent are strangers to each other. The fear of being rejected by the interviewee can be identified through observation of non-verbal communication behaviours.
- The users could say what the interviewer wanted to hear (McNeil 1990).

6.5.1 Users' Interview

Following ethical approval from the local Ethics Committee, interviews using a semi-structured format were employed to gather incidents from MHS users. Prior to interviews the author explained the purpose and reasons for conducting the study. The author visited the sites a few times to acquaint herself with the area and to find out more about the centres, for example how they were run. All the MHS users who attended the centres were no longer in-patients; some of them attended in order to seek opportunities for securing a paid job or seeking ideas about further education or simply socialising with others.

The researcher made an appointment with each of the users, who had given a time that was appropriate and convenient to them. If they were unable to keep the appointment they generally swapped with another. In fact, one of the users took charge of notifying the researcher about those who would be late for the appointment. The atmosphere was friendly and this reduced any barriers that would have been erected, had the interviews taken place in a hospital setting.

It was made clear that participation was voluntary and the respondents were free to withdraw at any stage of the study. An explanatory letter with a consent form attached, was handed to each respondent who volunteered for the interview (appendix 6).

Characteristics of sample population

A total of five males and five females volunteered for interview. Their ages ranged from 22 years- 65 years old. They gave written informed consent. They had been discharged from acute psychiatric wards for between six months to three years. The wards where they had been residents had claimed to have practised CCP.

Only those respondents, who had been hospitalised MHS users, at least during the past 3 years, were eligible to participate in the study. The reason for this was that the concept of CCP only appeared in the literature at that time (Working for

Patients, 1989; Caring for People, 1989).

The sample population was purposive and self-selecting; they could provide their perception of their role in participation in care. The purposive sampling is

“A process of seeking out informants because of the specialised knowledge of a particular topic.” (Field and Morse 1985: 95).

They knew each other so well that they were able to point out to the interviewer those who had been hospitalised. In one centre there was a man, who was articulate, seemed to know everything about everybody. Furthermore the others appeared to like him. He appeared to enjoy the privileged status that the others accorded him and, with that in mind, it is possible that some users might have felt peer- pressured into participation.

Setting for the interviews

Four interviews were conducted in one centre. In this centre there was no private room to carry out interviews; the users conducted their activities in a big hall of a local church. Four of the interviewees were females, aged between 36- 65years. All of them had been discharged from the in-patient care setting and had attended the day care facility following discharge. The interviews took about 30- 60 minutes, and were terminated when the respondent was unable to come up with further incidents (Norman, 1994).

In the other centre, interviews were conducted in a leased building, which had rooms used for different activities, to cater for users who wanted to watch television or smoke. The centre manager offered the researcher a private room for carrying out interviews, where there were fewer interruptions. Five men and one woman had their interviews taped recorded.

Interview process

The interviewees were first asked about the type of care facility they had been used to and the length of time after discharge (see appendix 8 for the interview guide). The MHS users were asked to give a retrospective account of their

involvement in care planning. To help them focus on the incidents the same questions were asked of all of them. The purpose was to elicit incidents in which they could describe how they and the health professionals decided on the care they received. The users were then asked whether they had had care plans. The question moved from basic level to more specific in order to isolate the incidents (Appendix 8).

6.5.2 Staff Interviews

A purposive sample of five health professionals, all females, volunteered to participate in the interview after the purpose of the study was explained. All gave informed consent (see appendix 7). The population sample of health professionals included two occupational therapists, one ward manager, two staff-nurses (both at grade D level).

The health professionals' interviews took place within the hospital setting, in one of the quiet side rooms. The 30-60 minute interviews were tape-recorded; procedures similar to those involving the users were adopted. Originally the time scale planned for completion of interviews was a month but instead the interviews ran over two months because of cancellation due to unforeseen ward-related events.

The staff interviews did not include CIT reporting. This was according to advice from the academic supervisor. However, the interview schedule, concentrating on the same five areas used more or less the same questions. The intention was to establish what constituted user involvement in decision making from the perspective of the health professionals.

6.6 Procedure for Analysing the Data

Initial impression of the interview responses.

The respondents were quite open about their experiences in relation to involvement in care planning. What was evident in the interviews was that the

incidents given were not numerous, as had been expected by the interviewer. Most of the respondents could not readily recall the situations in which they had been involved in planning care. The omission of that aspect of care still constituted an incident. Though they were not able to provide any rationale for their non-involvement in decision-making, they expressed a desire to be part of the decision making process. The analysis comprised a two-stage procedure: Thematic analysis and in-depth analysis. The thematic level describes the analysis of interviews as the researcher transcribed them. The in-depth level constitutes analysis of the 'critical happenings' contained in the incidents. The thematic analysis was informed by the work of Field and Morse (1985) and Burnard (1991). It takes the form of the inductive process of coding information into categories.

First step: as each interview was completed, information was sifted through to see any commonalities. Co-occurrences of words and phrases were highlighted in each interview. For example the word medication appeared in nearly most of the transcripts, which might indicate that the users felt the issue of medication to be of importance.

Second step; the researcher got 'the feel' of the interviews after several readings of the transcripts (Field and Morse, 1985). Co-occurrences were further identified manually using highlighting pens (Burnard, 1991). A cluster of the co-occurrences was grouped into categories. Categorisation of information led to formation of subcategories that were collapsed to formulate themes grounded in the users' own descriptive words. Interpersonal relationship underpinned the themes.

These themes that emerged from the interview were:

- "Coercion, not care", (not caring: no care plan: ward round: no partnership)
- "Have no power" (no shared responsibility: lack of control: imbalance of power)
- "Paying lip service" (Do as you are told: no consultation: no information:

physically seeking: medication only).

- “Know it all “(not involved in any decision making process: Hierarchical relationship: staff do not listen)”.

The theme of “Coercion not care”

Generally, the MHS users did not feel part of the multi disciplinary team, whereas health professionals were of the opinion that users were part of the team within the care setting. A difference of perception between users and health professionals is evident, for example, a generic concept such as care. One respondent user when asked about his role in care that he had received. He asked,

“What care! There was no care! The nurses may force you to have medication; I don’t see that as care. That to me is coercion” (User 1).

Indeed the health professionals acknowledged that often patients “on section “of the Mental Health Act 1983 felt that their rights were compromised because of the desire to meet the legal requirements. Another interviewee, who seemed negative about the idea of care, endorsed this.

“I did not receive any care except for medication. They don’t seem to have time for people like me as long as I take medication and do as they say, I’m no problem to them” (User 7).

What is demonstrated is a different perception and emphasis on what constitutes care. In the current climate that advocates collaboration in partnership between health professionals and users. Yet it generally acknowledged that health professionals have a duty to listen to users. The MHS users bring knowledge grounded in their personal experience; the nurse contributes information and relevant skills that enable the user to make informed decisions.

“In psychiatry they (health professionals) think you don’t know what you want and found that my problems were not taken seriously. Whatever I said was dismissed as part of my illness except forcing you to take medication” (User 2).

Of significant importance in the theme of “coercion not care” is the failure of the

health professional to interact effectively with MHS users and to exploit fully, such mechanisms as ward-rounds to promote patient collaboration.

“We collaborate with patients in planning. A group of professionals get together and plan care. They (users) usually agree with the content of the care plan” (staff 13).

It is evident from the comments that decisions are made for MHS users who, are later informed of the outcome. Mental health service users perceived receipt of medication in a negative way, whereas the nurses did not. While the health professionals acknowledge the impact of side effects of medication, the overriding benefit is seen as of paramount importance. The MHS users’ experience of the discomfort caused by side effects of drugs tends to colour their whole experience negatively. The prescription of medication appears to dominate user's hospital experience.

“I do not think I needed tablets. They (health professionals) obviously thought I did and was told medication was the best solution to my problems, I didn’t think so, I felt I needed counselling. But the health professionals did not take that seriously.” (User, 8).

These statements can be seen to reinforce this dichotomous perception between MHS users and health professionals (Speedy 1999). The findings suggest a considerable gap between health professionals and MHS users with regard to understanding the need for medication. Exclusively, MHS users perceive medication as the main tenet of care, prescribed and administered at times in the absence of obvious consultation. There is implied consent in the fact that the user is an in-patient. The users would like the health professionals to listen to their views and take them seriously (Epstein and Oslen, 1999).

‘Coercion not care’, implies a relationship in which there is lack of understanding between nurses and users. For therapeutic alliance to come about, nurses have to acknowledge patients’ experience (Speedy 1999). The use of different terminology causes ambiguity and can lead to inconsistency in understanding each other’s expectation (Wade 1995). In this context CCP is derived almost exclusively from the health professional’s perspective, and very

little from that of the MHS users.

The informants seemed to be surprised about the idea of collaboration. No opportunity had been taken to explain how they could be involved in some of the care activities that took place in the care setting. For example, the ward round where members of the multi-disciplinary teams meet to discuss each user's progress. Despite attending these meetings their role was always unclear. As a consequence a sense of being outsiders prevailed and they perceived that the ward round was of no benefit. Rather, many found it unhelpful and intimidating as evident in this statement:

“You go in and there are these people sitting facing you as if waiting for you to say something stupid” (user 1).

Another commented,

“I don't remember being invited, perhaps some patients were”(user 6).

The health professionals, on the other hand, acknowledged that the meetings were intimidating for users. Hence the named nurses often represented the user's interest.

By contrast another user, who was very articulate and assertive, looked forward to these meetings especially regarding section 117 of the Mental Health Act 1983. This is a multidisciplinary meeting aimed at facilitating post discharge care in the community. She felt her views were considered in these meetings and that she had an opportunity to clarify a few issues.

The theme “Paying lip service”

This theme “Paying lip service” indicated that health professionals did not always consider MHS users personal knowledge but instead tended to focus on the professional perspective of care events. The health professionals said that they took account of the users' views, but the latter did not believe it to be the case.

“Involvement is not meaningful because the actual content and the result comes from the health professionals. How strong do nurses care about

patient care ... they pay lip service". (User 3).

From the above comments, it might be seen that users perceive that any decision-making process should embrace genuine involvement but the structural hierarchical arrangement hinders any effective collaboration. A general feeling that their views were not considered, that the health professionals do not take seriously the ideology of genuine user participation is indicated by this statement.

"I didn't want more medication, I wanted to see how I could get on without medication, and my concerns were totally overlooked" (User, 8).

Consequently, the users didn't find the health professionals helpful when it came to decision-making about their care.

"Give people choice, some people may find it daunting at first because of their mental state, but I still feel they should be given all available options rather than paying lip service, making me believe they care about me (User 10).

Users want to be involved in care decisions; they wanted sufficient information to make informed decisions. One of the nurse interviewees commented on patient involvement in care decisions:

"That MHS users were given every opportunity to contribute to the decision making process. But those who are quite ill will often be left out of the decision making process." (Staff 12).

Information giving is an important aspect of decision-making. Numerous complaints brought by patients often involve lack of communication (Audit Commission, 1982). Lack of information may deter users from participating fully in the decision making process (Favod, 1993).

"There has got to be a recognition that patients have the right under Patient Charter. Structurally the patient's position is at the bottom of the ladder. There is no way of breaking the structure, it is set in concrete. When I participate in any situation I feel that they (health professionals) are merely going through the motions, just paying lipservice"(User 3).

This statement shows that users perceive participation in decision making as 'of right' although they believe that the health professionals pay lip service to the

idea of genuine participation. Urging the nursing profession to build on the traditional values, there is a need to adopt MHS users as equals and resourceful (Welsh Office, 1998). This is in keeping with modernisation of the health care services. Users should not have to ask for information; nurses have a duty to give them the necessary information (UKCC, 1992). Equipped with sufficient knowledge regarding their care, they can question care (Morrison, 1994). One user said that,

“Patients should not have to physically seek out information. Otherwise those users who are less assertive their concerns will be neglected” (User 9).

Implied in this comment is a requirement that information should be readily available lest the wants and needs of the quieter users would be ignored. If MHS users are to collaborate in decision-making about their care, the competence gap should be reduced.

“Have no power”.

This theme emerges from feeling of disempowerment. The MHS users felt that they have no power to influence the care process:

“As a patient you have no power. You don’t have a say about what happens to you. The whole relationship in hospital tends to build around hierarchical structures. I don’t think health professionals think of patients as anything else but ill people who need help. Luckily I demanded to see the doctor or ward manager. I had a flexible arrangement and I was satisfied with decisions. I can’t complain” (user 9).

There seems to be an expectation that once in a health care environment, MHS users do as they are told. A user commented on the hierarchical relationship that exists in the care setting.

“First, they (nurses) are not empowered because they are told what to do, the consultant is the important one. Nurses have no say, they are right at the bottom together with users who have no power at all.” (User 1).

Horsfall (1997) cites a MHS user who in a recent consumer research, described the hospital power hierarchies, as consisting of the actual doctors on the ward, and then the medical student, then the charge nurse and lastly brand new student

nurses, each level perceived as becoming less and less powerful, and the patient having no power at all.

Certain practices disempower MHS users, for example detention under any section of Mental Health Act is restrictive. The goal here is to ensure safety this may involve complying with treatment but there is:

“No need to be heavy handed. We need to change the culture, the whole social structure of the ward and the attitude of the staff I think things are changing slowly” (staff 14).

Implied in this statement is that the culture of the health care setting precludes full patient involvement and may thus disempower them.

“The culture does not recognise active participation of users. Health professionals are deemed to be experts,” (staff 11).

This staff member acknowledges that the system treats people with mental health problems differently and promotes a “them and us” division. The health professionals are not exclusively blamed for maintaining such a system. The MHS users acknowledge that the prevailing social environment is not always the fault of the nurses; a system defined within the medical paradigm accentuates a hierarchical relationship that offers little flexibility (Horsfall 1997).

“Knowing it all”

This theme encapsulates issues surrounding the way the MHS users and health professionals interact with each other.

“If you go to the ward as a visitor, it is noticeable the distance that exists between the health professional and users in terms of communication, They give impression that they know it all”. (User 4).

The statement indicates a sense of distancing experienced by MHS users, with the nurses less likely to engage in a quality conversation:

“The only people I had contact with in hospital were the domestics. I had some kind of relationship with them, none with the trained nurses” (user 3).

This reflects the literature that suggests that inexperienced and least qualified

staff spent more time in interaction with patients while decisions about their care are often made by senior nurses who may have less knowledge about users' progress on day-to-day basis (Robinson, 1996).

The MHS users may see nurses as presenting an aura of being busy with administrative tasks that normally take place in the office, so that there is little mixing with them. As a result the MHS users perceived the nurses' behaviour as displaying a stance of indifference to their needs.

"I do question some of the nurses who were more institutionalised than the patients. They acquired a language of indifference." (user 3).

It would seem from the above statement, that the health professionals regarded their position as superior to that of the users. Robinson (1996) found that nurses spent more time on administrative work than with patients.

"In a mental health hospital there is an assumption that we (users) are unable to make conscious decisions, therefore, cannot make a balanced judgement. The nurses and doctors know it all" (user 3).

Implied in the comments is that the health professionals do not appear to spend quality time with users. Thus the MHS users cannot contribute to the decision making about care planning if there is no dialogue.

"In the past users did as they were told without questioning because some patients have the attitude that, you know best, make the decisions for me" (staff 15).

Acceptance of the significant diverse views would promote social equality. 'Knowing it all' appears to be grounded solely on the possession of professional knowledge. While users frequently referred to 'know it all', the health professionals believe that the users hold the notion that they (health professionals) 'know best',

"Some patients have the attitude where they (users) feel you (health professional) know best. You make the decision for me because you know what is best for me." (Staff 15).

It can be said that the health professionals may unwittingly encourage

dependence and passivity on the part of the users. Adopting a 'know it all' stance could be a defensive mechanism, as nurses feel threatened by MHS users having a strong role to play (Saunders, 1995). It could also be argued that the health professionals have some reservations about users' ability to collaborate actively in decision-making.

6.6.2 In Depth Critical Incidents Analysis.

Using a computer analysis programme (Paradox 7 1997) incidents were demarcated into discrete categories. In this study "critical happenings" included observed events and those that the MHS users personally experienced in relation to planning of care. The "critical happenings" have a meaning for the user. This was clearly demonstrated by one user who remarked:

"The doctor/nurses document all the treatment that patients receive so that's why I know I had a care plan" (user 9).

The user was aware of the existence of a care plan but was not involved in the care planning process.

The interviewer has followed Norman et al (1992) in rejecting an incident as the basic unit of analysis. What has emerged is that the "happenings" embedded in the incident, which are of great significance to the user.

"Critical happenings always have a positive or negative value for the respondent since they are revealed in response to request" (Norman et al 1992: 597).

The MHS users elaborated on the critical happenings that were of importance to them. In most cases the MHS user did not remember when or how the incident occurred but recalled the care events associated with the incident. For example, on asking a respondent whether she had contributed to decision-making regarding her plan of care, the response was:

"I did want to speak to the nurse in charge but they (nurses) told me he was busy, and that he did not have time. The nurses were always busy in the office" (user, 7).

The respondent could not remember the context of this incident but recalls the

critical happenings. The happenings include the fact that the user wished to talk to the nurse in charge, and that she expressed the meaning of these happenings negatively.

Once the “critical happenings” had been identified, an independent health professional, which was conversant with CCP, scrutinised and challenged the identified happenings and categories. The independent evaluation of critical happenings increased the confidence in validity because the happenings appeared to reflect the content of the interviews.

Critical Happenings

Analysis of the incidents revealed critical happenings, meanings and the following main themes were then formulated:

- Classification of incidents incident or not incidents
- Involvement -- non involvement in care
- Imbalance of power
- Contextual factors in involvement
- Tone of the critical happenings

Classification of Incidents

Incidents were classified either into incidents, general, or other (dross). Some of the incidents did not directly relate to the areas under exploration but were nonetheless important to the users. In total 509 incidents were derived from the interview data, of which 97 were of a general nature and 412 were more specific to the aim of the study (Table 12).

Some incidents ran into each other as opposed to being demarcated as Flanagan (1954) suggests. Others contained one or more critical happenings. The interviewer found that each ‘happening’ attracted a meaning or even meanings. To illustrate the “critical happenings” (Figure 13) the following interview extracts of a user who had been sectioned under the Mental Health Act (1983) describes what he observed and experienced during a ward round are worth noting:

“That even ...send you in this room and you sit there. It’s a bit like something out of a cartoon; you sit around facing the doctors and nurses. There is one doctor a consultant who asks you a few questions; they basically wait for you to say something stupid. They don’t answer, say something, about medication but more often than not, they would say you need more injections that sort of thing, you know what I mean.”(User 1).

This user perceived the ward round as intimidating, which is the meaning he attached to this particular critical happening.

“If you have what they call psychosis, whatever you say, they don’t listen, whatever you say, and they don’t take you seriously. When you are in that state of mind you might be jumping around talking absolutely nonsense, there are parts that rational everything you say should not be dismissed as nonsense” (user 1).

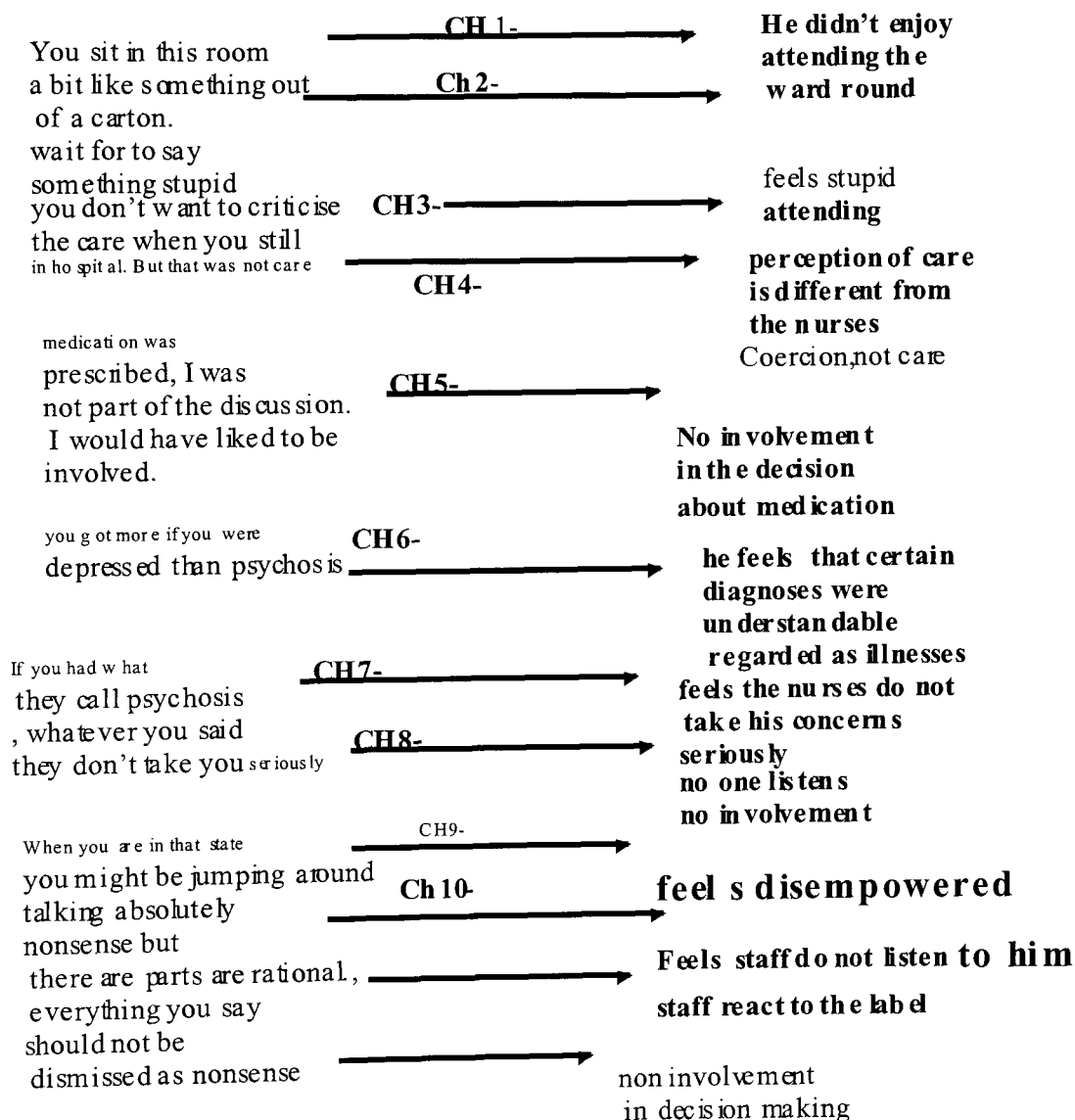
What emerged was that although happenings were always associated with a meaning, occasionally the MHS users were unable to elaborate. That was a “happening” but despite further questioning the user was unable to expand on the meaning. However, the experience to him was of a negative value this was identified as an instance of non-involvement in decision-making (Figure 13).

Figure 13 An example of critical incident showing critical happenings

describes his observation of what happened in a ward round

critical happenings

Meaning



Ch= critical happenings

-/+ value judgement with regard to involvement

Involved – non-involved in care

As previously stated there were 509 incidents. Of the 509 incidents only 15% indicated that the users were actually involved in the decision making about their care. A large majority of incidents indicate that the users were not involved. Twenty per cent of critical happenings were classified as “ others” because there were not addressing the process of the involvement in care. However, the users perceived them to be important and positive. (See table 9).

Table 9: Incidents showing the level of involvement

Involved		Uninvolved		Other		Total	
N	%	N	%	N	%	N	%
78	(15%)	329	(65%)	102	(20%)	509	(100%)

To illustrate an incident with a critical happening in which the user was uninvolved, an interviewee explains his experience. He was disappointed at the lack of involvement, to emphasise his point, he compared how if he had a physiological problem with his leg, he would be given more information about it, in the general nursing care context.

“At the very least I would be really upset, that I would like to know in theory why they were to amputate my leg. There must be a good physiological reason for that. But in a psychiatric hospital, there is an assumption that we (users) are unable to make conscious decisions. There is an assumption that I can’t make a rational decision, a balanced judgement, the nurses and doctors know it all.” (User 3).

This statement reflects the MHS user’s feeling about how he perceived the care he had received in a psychiatric hospital. He found that he was not consulted about his care plans. This reflected what the user had observed and experienced and perceived as a ‘non-involvement’ incident in a decision-making process.

Some critical happenings indicated that there was very minimal involvement in care planning. However, when asked,

“Is there anything else that could have been done to help you partake in your care?”

One respondent answered:

“I would have liked to discuss what was happening to me, at least, someone to talk to” (user 9).

This implies that the health professional communicated minimally and the user did not feel involved although he would have liked to have been. Another interviewee commented on how nurses were too preoccupied to discuss her concerns. She felt the nurses were always busy and users had to “physically seek information”.

However, a comment from the occupational therapist maintains that involvement may not always be possible for all users.

“Some may not wish to participate or be too ill to contribute. It should be left to them as long as they are aware of the options,” (staff 11).

Similarly the nurse interviewee felt that the nurses’ attitude interplayed significantly on the extent of user involvement in a joint planning of care:

“The attitude of some professionals was off putting”(staff 13).

Both health professionals and MHS users are of the same opinion that users should be actively involved in planning care. Interestingly though, the health professionals felt that the MHS users were already involved but more could be done to increase the level of involvement. One staff interviewee recommended providing comprehensible information to enable the users to make informed decisions, relevant information in a language that they can understand. In addition health professionals need to respond to user feedback. One nurse commented on the attitude.

“...The right attitude of the staff will enable patients to approach them more freely and voice their concerns; encourage patients to question their care if unsure. I think they can only do that if they are well informed of the various options available. The health professionals should increase their communication and spend more time with patients. Even putting up notices and things like that perhaps would help to enable patients to access staff more readily”(staff 14).

It would seem the most important thing is availability of staff and the right attitude of friendliness is an important prerequisite for MHS users to feel part of the care team.

Imbalance of Power

The MHS users were asked if there were times when they felt overpowered. The critical happenings in these incidents revealed a hierarchical–controlling relationship (included are the following categories “rigid culture”, “they don’t care”, “distancing”, “lack of control”) that disempowered the users. Fifty one point one per cent of the incidents indicated such a relationship, whilst 29% indicated a “supportive relationship” which comprised, “caring and listening” to their concerns, and “treated as a human being” another 20% expressed no particular relationship (see Table 10).

Table 10: Shows distribution of the number of incidents in each category in the Contextual factor/Imbalance of power.

	Controlling	Hierarchical	Other	Supportive	
	N	N	N	N	%
Care plan	58.	51	12.	81	39.7
Medication	38	20	2	18	15.3
Ward round	62	21	84	8	34.5
Personality	4	2	2	40.	9.5
ECT	3	1	2	0	1
Total in N=	165	95	102	147	509
Per cent	32.4%	18.6%	20%	29%	100%

It was clear in some instances that in spite of not being involved in decisions about their care, some incidents indicated that users still found the relationship supportive. Even those who had highlighted medication as the main element of their care, and felt that they were not consulted nor given detailed information, found the relationship still supportive (see above table 10, there are 18

incidents).

“ I found the ward manager quite good. I was given more time but I was not introduced to my primary nurse. What they tend to do is give you a piece of paper telling who your primary nurse is and I did not have much to do with him.” (User 9).

Twenty per cent of incidents relate to medication as the main source of concern and the users would have wanted more information about the side effects.

“I was not given sufficient information about side effects that were crippling me”. (User 2).

Contextual Influence

This theme emerged from subcategories that included personality of the health professionals and other attributes that appear to play an important role in enabling users to be involved in care. The critical happenings in this theme relate to the contextual influences that enable users to collaborate in decision-making. It was essential to have an insight into what users consider to be the critical attributes of working together with health professionals. It was difficult to establish from the critical happenings what constitutes the critical attributes of user collaboration. For example, some critical happenings indicated that user involvement in care occurred despite the absence of a supportive relationship.

Two hundred and one incidents referred to the process of care planning (37.7%), as a vehicle for bringing users' knowledge and that of health professionals together to address their health related concerns. Reference to care plans indicated how the users would wish to 'see what was documented' about them, not to make any entry. Making an entry in the document was thought to be of little significance, something to be “left to the professionals”.

“I think patients should be allowed to see what is kept on them, it is nice to see what they write about you and you can ask further questions,” (User 4).

Seeing the care plan is perceived as an important aspect of care. This finding is consistent with the questionnaire results in which the service-users ranked

'seeing records' as the most important element of working together with health professionals. On the other hand the occupational therapist stated that MHS users were allowed to see, and agree to their care plan.

"With our care plans they (user) have actually a space at the bottom to tick to indicate their agreement with the care plan" (staff 11).

Making an entry has not been encouraged. The nurse respondent wondered about how allowing users to make an entry would work in reality, but admitted that letting users see their records was a step in the right direction.

"It would tighten up on things. Nurses will be cautious of what they write but I don't think patients are concerned about documenting. I think a lot of patients feel helpless"(Staff 15).

It could be that the users do not perceive documentation as an issue because of lack of awareness of the options available to them. The contextual influences that emerged from the incidents include qualities of the health professionals, these are: "kindness", "friendliness", "nice", and "understanding"

Another user interviewee described an incident in which she and the social worker sorted out entitlement to benefits. She identified this type of relationship as conducive to encourage participation in care.

"Being treated as people, respect you as another human being and respect your wishes" (user 7).

The health professionals do not identify these qualities in their interview data as the critical attributes of collaboration. They nevertheless concede that attitudes and the culture and relationship between users and health professionals need to change. In order for MHS users to adopt an active role, the culture has to reflect the users' ideology. Society has conferred a lot of power and authority on health professionals. Consequently it would appear that the MHS users do not think of challenging what professionals do or say, but accept it unquestionably. Unless the MHS user is assertive and knowledgeable s/he will tend to concur with whatever suggestion is proposed.

The interpretative paradigm would suggest that:

“Reality and social world is created by the actors through assigning meaning systems to events” (Sarantakos, 1994: 35).

Relating to these findings, this theory suggests that because of social conventions, primarily the dominance of the medical model, the MHS user has adopted a passive role. Society has expected MHS users to adhere unquestioningly to treatment or care prescribed by those upon whom society has bestowed authority and status because of their specialist knowledge and training. The users’ own knowledge has been of secondary importance in aiding a joint decision about care planning.

Tone of critical happenings:

Happenings were assigned a negative or positive tone according to how the users perceived it in relation to “working together with health professionals.”(Table 12). Thirty-one per cent of the incidents revealed happenings that were considered to be positive (or good and beneficial). The meanings ascribed to these happenings were based on the users perception of events related to their involvement in care. However, in some instances the users perceived critical happenings as positive even though they were not involved in care. Influences exerted by the other contextual factors would account for the positive tone. For example, one male user described an incident where his primary nurse made all decisions. The primary nurse took him shopping as part of his care plan. She purchased all the items that she thought he might need.

“No I did not need to have an input because I was satisfied with all decisions made for me. They know what’s best for me” (User 2).

The user felt supported and was positive about the happenings despite not participating in decisions of care events. Thus, he may be said to have fulfilled the requirements of the sick role (Parsons, 1975). However, as far as he was concerned his health related needs were being met.

Lastly there were ‘non-happenings’, which involved omission of care but the

users still considered them as important. In this analysis critical happenings that did not fit into either positive or negative category were classified as ‘others’. These incidents were equivalent to what has been referred to as dross; these amounted to 7.3% (see table 12).

Table 12: Tone of incidents either positive/negative or others

NEGATIVE	INVOLVED	3 (.5%)
NEGATIVE	UNINVOLVED	177 (34.8%)
NEGATIVE	OTHERS	23 (4.6%)
POSITIVE	INVOLVED	66 (13%)
POSITIVE	UNINVOLVED	102 (20%)
POSITIVE	OTHERS	42 (8.3%)
OTHERS	INVOLVED	9 (1.8%)
OTHERS	UNINVOLVED	50 (9.8%)
OTHERS	OTHERS	37 (7.3%)
NUMBER OF INCIDENTS		509 (100%)

Critical Attributes

Allowing the users to describe incidents, in which they were involved in decision making of care, isolated the critical attributes encapsulated in collaboration. From the incidents studied critical attributes similar to those denoted in the literature were not evident. When asking the users to state what would help them to collaborate genuinely, the antecedents identified revealed a list of qualities inherent in a counselling relationship (Roger, 1980): for example, qualities such as:

“She was nice to me, could make jokes and make me laugh, she had time

for every patient” (user 8).

To this user the personal qualities of the nurse significantly influenced the outcome of the relationship. Another interviewee describing the student nurse as:

“Lovely person, had time for patients. She could do anything you asked but of course she was not trained she could not advise you on anything.” (User 5).

These statements demonstrated that these qualities were admirable and valued. The qualities that the users described were not always encountered in every interaction they had with health care professionals. The findings seem to suggest that the form of care planning that is espoused in the literature appears to be non-existent in practice. On that basis it can be said that CCP in clinical practice may exist but the MHS users do not recognise it as such. There is no clear consensus as to the role of the users in CCP process. Despite patient participation being heralded as desirable outcome (Cahill, 1996) in reality it is a different picture.

6.7 Interpretation and Discussion of the Findings

A majority of incidents indicated critical happenings that denoted very little involvement of users in planning care. There are six issues that are noted in relation to the findings: Firstly, the health professionals perceive involvement in care differently, arguing that involvement was dependent on intrinsic factors such as the users well being or age. Overall, the health professionals claim that users are encouraged to partake in decision-making but they acknowledge that a forum such as the ward round could actually intimidate the users.

For users to be involved in any collaborative process, there needs to be a formalised way for them to take part in care so that there is some evidence to that effect. Shared decision-making can be formalised in care plans and both user and health professional signatures endorsed. This would cater for the wishes of those

users who are ready to collaborate and those who do not wish to. This would recognise that the users are not a homogenous social group.

Secondly, some critical happenings showed that users were not involved in care or decision making yet, in fact, perceived the happenings as positive because of the kind of support and qualities displayed by the health professionals. Those that the users could not identify as either positive or negative were assigned a category of 'other'. The meanings were not well articulated, but were of importance to the users.

Thirdly, the theme 'imbalance of power' revealed that the relationship between health professional and users was hierarchical and controlling. This appears to prevail to a greater extent; this kind of relationship could appear to disempower users. This echoes the findings of Morrison (1994) who found four themes in one of which patients adopted a particular mode of self-presentation, which apparently helped the patient to cope with the hospital experience. This can be related to the MHS user in that the physical setting of the clinical environment and the social environment play a great role in facilitating the way the user feels about involvement in the care plan. Consequently the user's behaviour changes to fit in with what is required. This could be viewed as characteristic of being a patient within health care setting (Morrison 1994).

Many users may not critically question their care. They appear to hold the view that doctor/nurses know what is best for them (Henderson 1997). It can be argued that the biomedical approach fails to promote users' responsibilities over their care. The constant reference made to medication is a good example. Yet none of the users questioned the delivery of care administered by the health professionals.

Illich, (1976) cited in Senior and Viveash (1998) in criticising the medical model he talks of clinical iatrogenesis caused by the side effects of drugs. Furthermore he blames Medicine for society's failure to seek actively alternative

options for solving problems. Instead he argues that it encourages individuals to depend on medication that causes what he calls 'cultural iatrogenesis'.

In the absence of information, there is a tendency to believe that shared responsibility or shared knowledge would be compromised. Lack of information disempowers users and fails to promote social equality in the care setting (Beresford and Croft 1995).

Fourthly, for effective involvement to take place in planning care, it would appear that the prevailing traditional culture would need to change to accommodate the new image of the user in health care system (Walsh 1998). The emphasis is on developing interpersonal skills within a facilitative social environment, this will help the health professionals to work towards a co-operative relationship that has benefits for both users and health professionals.

Fifthly, findings from the critical happenings reveal very minimal collaboration between users and health professionals. In addition the incidents seem to suggest that the social environment could be conducive to working together if qualities of health professionals, such as those of friendliness and supportiveness, were present. This calls for unravelling the social structures that distort the communications. The critical happenings contained in the incidents related to involvement in care failed to provide a clear picture of the role of the user in decision making about care. Some critical happenings showed a degree of involvement despite a hierarchical controlling relationship.

Sixthly, despite the desire to be involved actively in the decision making about care, users have not articulated how this could be achieved. The users also expressed a wish to see what was written about their care. The feeling seems to be that the MHS users wish to know what is written about them, not necessarily to make any entries themselves. Equally the health professionals concur with the idea of the users seeing their records instead of making an entry in the care plan. One way of accomplishing this could be a contract drawn between users and

health care professionals that contains accepted, realistic and reasonable goals and integrative solutions. The contract would clearly stipulate the actions that each has to undertake and there must be signatures to that effect. However, it was interesting that the occupational therapist have already achieved this ideal.

Health professionals, though not specific about the qualities that are conducive to working together with users, concede that good interpersonal skills, change of attitude and culture would support a working together approach to care.

Involvement, patient participation, patient collaboration are all social processes that need to be clarified in order for all parties to have the same conceptual understanding of the meaning. Health professionals and MHS users need to come to some consensus as to the appropriate term that affords clarity of roles and how the user can participate in decision making in an effective manner.

6.7.1 Critical Theory Can be Used to Explain the Findings.

The critical theory perspective grounded in the Frankfurt School of Sociology suggests that human beings, in these instances MHS users, have a great potential for creativity and adjustment. But they are restricted by social structures and conditions. The aim of critical theory is to unfreeze these law-like structures that may be hindering MHS users from full participation in care and to encourage self-reflection for those whom the laws apply. Through critical incident technique MHS users were encouraged to reflect on their participation in care planning. “The unfreezing allows for unquestioned assumptions to be examined, such as who constructs and maintains barriers” (Wilson-Thomas 1995:573). This allows the examination of unquestioned assumptions associated with the role of user and that of the health professional. It may be questioned, for example, why the role of the user is perceived as a passive recipient of professional decisions /instructions and further examine the structures that may be creating barriers collaboration in care.

Habermas (1979) argues that the twentieth century has seen the rise of technocratic consciousness. The answers to problems are increasingly seen as technical rather than ethical issues. The MHS users feel that the health professionals see their problems as grounded in technocratic solutions, hence the emphasis on medication. The users are, therefore, not expected to take an active role in discussing their perspective about medication, for example.

“Communicative Action” describes this freedom from value-rational action. The theme of ‘involvement-non-involvement’ indicates that there is still a “culture of distancing” from users. Consequently the MHS users perceive the health professionals to be absorbed in a technocratic consciousness, for example in administrative tasks. The finding suggests that communication is often distorted, as CCP is not grounded within the users’ perspective. The health professionals believe they know what the users are going through. This is theoretical knowledge of what the user is expected to experience. The findings suggest a much more illuminative dialogue is needed to enable the MHS users to judge or challenge the quality of care they are receiving.

6.8 Conclusion of CIT

It was hoped that through using the CIT the MHS users would identify the role they played in deciding their care. This would indicate to what extent MHS users’ contributions to care were valued, and furthermore determine what strategies could be adopted to ensure genuine participation in decision-making process. It would also explore the form of social environment that would be conducive to promoting collaboration in care.

Thematic analysis revealed four themes; these were grounded in the users’ words. They included “Coercion not care”, “Have no power”, “Paying lip service” and “know it all”. These themes demonstrate very little involvement in decision-making. However, they demonstrate a range of relationships between the users and health professionals.

In-depth critical incident analysis was carried out. Four themes emerged, these included “incidents not incidents”, “involved-non involvement”, “imbalance of power”, and “contextual factors in involvement”. The critical happenings were considered to be the basic unit of analysis and revealed absence of CCP, from the users perspective. What emerged from the incidents was a repertoire of qualities that users perceive as admirable and valued when displayed by health professionals. The attributes identified are positive in encouraging a relationship. It can be argued, would facilitate collaboration.

The critical happenings in the incidents do not reveal the role the users played in decision-making. The incidents show minimal involvement in some cases despite the controlling relationship exerted by the health professionals. The opportunities to develop collaborative relationships were not always available; those who did participate did not feel their views were taken seriously culminating in a state where they felt not valued as patients. Humanistic care entails treating people as other human beings with values and beliefs. Users can be empowered by embarking on social processes that promote and develop users' abilities (Gibson, 1991). Those social processes need to be transparent and satisfy individual's expectations about their role in health care.

MHS users require some social processes that enable them to partake in care planning, if they so wish. Users may be enabled to have control over their care and responsibility for their lives. Generally the reality of what happens to the user in the care process is based on the reality perceived by health professionals (Avis 1995). This may be contrasted to the reality grounded in the values and beliefs of the users. The findings indicated that that the users perceived that their views were just as important as those of the health professionals. Health professionals may be disempowering the users by perpetuating a culture that actively promotes patient dependence and a state of powerlessness (Morrison, 1994; Horsfall, 1997).

6.9 Worthiness of the CIT Study

Qualitative research tends to use terms such as establishing true value, applicability, consistency and neutrality (Marshall and Rossman, 1989). The true value of the qualitative approach should be judged by its worthiness and truthfulness of the findings. Evaluation can only be achieved by taking data and interpretation back to the respondents, asking them whether they recognise their specific pieces of information given during the interview process (Lincoln and Guba, 1989; Silverman 2000). Returning the data to the MHS user interviewees to ask them for their comments on the interpretation was not successful as only two of the users were available. Because of the length of time that had elapsed since the interviews were conducted they were unable to recall the details of the interview although they remembered the interview process-taking place. However, they were able to recognise some aspects of their narration.

Caution has to be exercised because showing the respondents the transcripts may not always be possible and may actually distort further information. As there may be an attempt to provide answers and information that they think the research lacks (Silverman 2000). Furthermore, the respondents' evaluation cannot always guarantee truthfulness or refutation of the interviewer's inferences (Fielding 1993).

A colleague was asked to examine the transcripts to see if they could identify the same categories (Field and Morse, 1985; Burnard, 1991). Three transcripts were randomly chosen from all the transcripts. The independent colleague read the transcripts through and produced categories which approximated those that the researcher developed. However, the independent reviewer felt that on one occasion the themes were open to wide interpretation e.g., imbalance of power. After further discussion a consensus was reached and this was used in the report.

Applicability of the Findings

The interviewer has provided a detailed account of the methodology. Hopefully if this study were to be replicated there would be a chance of being able to

follow the research process to produce more or less the same findings to answer to the research question. The practitioners in the mental health service should be able to see the findings of the study as meaningful, relevant and applicable to other areas that are promoting CCP. The two strategies that Burnard (1991) recommends as possible checking for validity were applied to this study namely *consistency* and *neutrality*.

Consistency

The quantitative approach aims to replicate the methodology and produce more or less similar results. The qualitative approach on the other hand, emphasises the uniqueness of human phenomenon and the significance of the experience that is not objectively measurable (Creswell, 1994). A detailed account should give the reader clear 'route' that was taken to arrive at the analysis. However, the results may be totally different because of the uniqueness of human experience.

The study may be judged as auditable as long as the reader can understand the rationale for decisions taken. The reader should be able to follow the decisions taken on every stage of this study (Morse and Field, 1996). Provision of a detailed description of how the interviews were conducted and the transcripts analysed was a way of ensuring that the reader can check and follow the decisions taken.

Neutrality

Neutrality entails freedom from bias in the research process (Lincoln and Guba 1985). In an endeavour to prompt the interviewees to provide critical incidents, the probing manner of the researcher may have introduced interview bias. The interviewer tried to reduce potential bias by not pressing for further incidents once the respondent could not think of any more. Bias could have been introduced by the fact that the respondents were self-selecting and purposive, they might have had negative experience that could have clouded their perception of care events.

6.10 Limitation of the CIT

The findings should not be extended beyond the population studied for the following reasons:

1. The purposive and self-selecting sample could be composed of those volunteers who had had an adverse experience, which might have clouded the whole experience about the mental health care system. However not all MHS users were negative about their experience. Some of the MHS users preferred non-participation in the decision making process.
2. Social desirability: it is possible that the respondents provided information that they thought the interviewer wanted to hear.
3. Retrospective amnesia: It is possible that forgetfulness of some detail associated with the critical incidents may have affected the true understanding of the activity under investigation. On few occasions it was difficult for respondents to give an in-depth description of the happenings despite being prompted. and they could have had selective memories of what care events they found negative.
4. The MHS users tended to provide a string of incidents sometimes not directly connected to the areas under exploration. Conversely from the fact that they were able to describe the incidents, it might be said that those incident were of great importance to them. Critical incidents that were irrelevant to the involvement of care were classified as “others”. Further analysis carried out to look for significant meanings derived from them.
5. Some incidents described were too brief to illuminate the critical happenings associated with areas under investigation.

Appendix 6: Explanatory letter to users

Dear

I am carrying out a research project on 'Collaborative Care planning' as part of my nursing degree. Collaborative care planning involves patients working together with Health professional (nurses, doctors and social workers and etc).

I am interested in finding out your views about your role in working together with health care professionals. In order to obtain this information I'm asking you to participate in an interview. The aim of the study is to find out about your experience of involvement in decision making of your care plan.

Your participation in this study, hopefully, will increase our understanding of how best patients and staff can work together in planning care.

The interview will take place at the Centre, last approximately 40-60 minutes and will be taped recorded. Information will be transcribed and computer used. When the information from the tapes has been used. All the tapes will be erased.

May I stress that any information you provide will be treated in confidence and no names will be disclosed or appear in the report. The information you give will not be attributable to you.

I would therefore be grateful if you suggest a date and time most convenient to you, possibly between 20/8/98 and 28/9/98 to meet for the interview.

Please find attached a consent form for your completion. I will personally collect the form.

May I thank you in advance for assistance.

Yours sincerely

Elizabeth Williams

✂-----✂-----✂-----

Consent form

I agree/ do not agree to participate in the research study of collaborative care planning as described in the explanatory letter. I understand the purpose and the nature of the research project and I am participating voluntarily

I give my permission for information to be used in the compiling of the report. I have been reassured that my name and any other information will not be attributable to me.

I will meet for interview, which I am informed, will take 40-60 minutes and will be tape-recorded.

Respondent signature..... Date.....

Witness signatureDate.....

InterviewerDate

Appendix 7: Explanatory letter to Health Professionals

Dear colleague

Re Collaborative Care Planning: Users' Perceptive

As part of my research degree at the University of Glamorgan, I am conducting a study on 'Collaborative care planning'. The aim is to elicit views of health professionals and patients on collaborative care planning and to determine how patients would like to be involved in decision making, if they so wish.

Interviews will be undertaken in order to explore some perspectives that emerged from the initial analysis of questionnaire survey conducted among both patients and health professionals.

I'm writing to ask if you would like to participate in an interview, which hopefully will increase our understanding of the concept of collaborative care planning and inform practice.

The interview will take place at your location. It is anticipated that the interview will take 60 minutes and will be tape-recorded.

I would be grateful for your assistance and can assure you that any information you give will be treated in the strictest confidence. No information in the report will be attributable to you. Once the report is compiled all tapes will be erased and any raw data destroyed.

It is anticipated that the interview will be conducted over a two-week period starting from.... to.....

Please find attached a consent form for your completion and hand to me

May I thank you in advance for assistance?

Yours sincerely,

Elizabeth Williams

✂-----✂-----✂-----

Consent form

I 'm willing/ not willing to participate in the research study of collaborative care planning as described in the explanatory letter.

I am willing to give permission for information to be used to compile the report and I understand that nothing I say will be attributable to me.

I will meet for interview, which I am informed, will take 30-40 minutes and tape-recorded.

Respondent's signature..... Date.....

Witness signatureDate.....

InterviewerDate.....

Appendix 8: PATIENTS' INTERVIEW SCHEDULE

Background

1. Length of time spent in a mental health service?
2. Type of care setting
3. Involved in hospital ward round?
4. had care plan?

Collaboration

1. Think of a time when you were involved in the planning of your care. (Pause until the respondent indicates he/she has such an incident in mind).

1.1 Tell me what part did you play in the discussion of your care? Can you give me an example?

1.2 Do you think your views were taken into account?

Yes - tell me how/ give me an example (repeat as often as the responses are forthcoming)

Were there times when your views were not considered (Probe for clarification)
Please tell me in what ways your views were not taken into account?

1.3 Did you think they were helpful to you?

Yes - In what ways were they helpful? Please can you give me an example (repeat as often as responses are forthcoming)?

1.4 No - can you think of a time when in your opinion, the staff was not as helpful in the discussion as you would have expected them to be. Why do you think they were not helpful?

1.5 In your opinion do you think you were given sufficient time/opportunity to explain yourself/put your point-of-view across?

Yes - tell me how (probe for further clarification)

1.6 What do you think of the help you got from the Health Professionals? Is there anything else that could have been done to help you partake in your care to your satisfaction?

Imbalance of Power

2.1 Was there any time when you felt overpowered/overwhelmed by being involved in the discussion of your care? Yes - please explain

2.2 Do you think you contributed to your care in the way you wanted to?

Yes - tell me about it (Probe)

No - what do you mean?

2.3 Was there any time you felt you were pushed to partake in the planning of your care when you were not ready? Can you explain that to me? (Repeat as often as the responses are forthcoming)

2.4 How did you feel about?

Control of Care

- 3.1 Can you remember a time when you felt you had any control over your care?
Yes - please tell me about it. Can you think of any other times?
- 3.2 Do you think you had as much help, as you would have liked to help you to be in control of your care?
What sort of help did you have? (Probe for incidents)
- 3.3 Are there any times when you have in your opinion thought other things could have been done to help you more? (Repeat as often as the responses are forthcoming)
Yes - tell me what they are?
- 3.4 Were there times when you felt that you would have wished to have control over your care When was this?

Decision-making

- 4.1 What do you understand decision-making to mean in relation to care planning?
- 4.2 Can you tell me of a time when you were satisfied with the decision-making of your care planning?
- 4.3 What part did you play in the decision-making process? (Probe for clarification)
- 4.4 Can you tell me of any time when you felt the decision made about your care incorporated your views? (Probe for clarification)
- 4.5 Were there times when you have felt left out in deciding your care? How did you feel about that?
- 4.6 If you were not involved in the decision-making of your care, would you have liked to be involved?
Yes - tell me in what ways would you have liked to participate.

This is end of the interview. I very much appreciate your contribution.

Thank you so much for your time

Appendix 9: Interview Schedule for Health Professionals

Background

1. Length of time working in a mental health service?
2. Involvement in care planning.
3. Length of collaborative practice in care setting?
4. Type of care setting

Collaboration

1. Think of a time when you were involved in the planning of patient care. (Pause until the respondent indicates he/she has such an incident in mind).

1.1 What part did the patient play in the discussion of his/her care? Can you give me an example?

1.2 Do you think patient's views were taken into account?
Yes - tell me how/ give me an example
No - why not?

1.3 what do you think the patients felt about discussing their care with the Health Care Team? (Probe for clarification)

1.4 Do you think the patients find discussing their care with health professionals helpful?

Yes - In what ways were they helpful? (Please could you give me an example)?
No -, in your opinion can you say in what ways were the staff not as helpful in the discussion as you would have expected them to be. Why do you think they were not helpful?

1.5 In your opinion, do you think patients were given sufficient time/opportunity to explain themselves/put across their point-of-view?

Yes - tell me how
No - why not?

1.6 What could be done to ensure patient help patients partake in their care effectively, if so wish

Imbalance of Power

2. Was there any time when you felt patient were overpowered/overwhelmed by being involved in the discussion of their care? Yes - please explain

2.2 Do you think patients contribute to their care in the way you would have wanted them to do?

Yes - tell me about it
No - what do you mean?

2.3 In your experience do you think that patients partake in the planning of their care/as much as they wanted to/to their satisfaction?

Yes - could you please explain?

Control of Care

3.1 Did you feel patients have as much control over their care as they would wish to?

Yes - please tell me how

No - why not?

3.2 Would you say patients have as much help, as they would like to exercise control of their care?

Yes - please explain

No - why not?

3.3 In your opinion were there other things that could have been done to help them more?

Yes - can you give me an example?

Decision-making

4.1 What do you understand by patients' involvement in decision-making to mean in relation to care planning?

4.2 Can you tell me of a time; in your views patients were satisfied with the decision-making of their care planning?

4.3 What part did the patient play in the decision-making process?

4.4 Can you think of any time when you felt the decision made about patient's care incorporated their views? (Probe for clarification)

4.5 If patients were not involved in the decision-making of their care, would you have liked them to be involved?

Yes - tell me in what ways would you have liked them to participate.

This is the end of the interview. I am much obliged for your contribution.

Thank you so much for giving me your time.....